

**PRESERVE SAFETY NET
REPRODUCTIVE, SEXUAL,
AND MATERNAL HEALTH
CARE SERVICES**





PRESERVE SAFETY NET REPRODUCTIVE, SEXUAL, AND MATERNAL HEALTH CARE SERVICES

Many U.S. women rely on safety netⁱ providers for reproductive, sexual, and maternal health care. The Institute of Medicine defines the safety net 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.”¹ In 2007, over 45 million Americans did not have health insurance and 39.6 million were covered by Medicaid, making the safety net a primary source of health care for nearly one-third of the U.S. population.² Furthermore, since 2007 the number of unemployed has increased by seven million, adversely affecting the health coverage of those with employer-based insurance and increasing the demand on the safety net.³ The National Association of Community Health Centers reports that sixty million Americans now lack adequate access to primary care.⁴ Even with comprehensive health care reform, without sufficient health care providers willing to serve communities most in need, improved health insurance will not necessarily result in improved access to health care.⁵ Overall, providers are limited, funding is scarce for safety net services, Medicaid budgets are strapped, unemployment is on the rise, and health care disparities for the impoverished and marginalized persist, making the preservation of the safety net a tenuous yet vital task. Local communities, where the impact of the safety net can be felt most acutely, are perfectly positioned to improve the health of residents by strategizing together on how to preserve the safety net for those most in need.

THE IMPACT OF INSURANCE COVERAGE

Having comprehensive health insurance greatly impacts access and ability to achieve optimal health. Nationally, almost half of poor women in their reproductive years are uninsured.⁶ Even more are considered underinsured, meaning their health coverage is inadequate and forces them to incur out-of-pocket costs or not seek care at all. A recent survey revealed that 45% of all U.S. women were either uninsured or underinsured.⁷ Uninsured women are also less likely to receive

recommended preventive care, including Pap testing, and more likely forego prescription medication.⁸ People of color, especially Latinos, are more likely to be uninsured or rely on public insurance for their health care.⁹ While women of color comprise 32% of the U.S. population, they represent 51% of U.S. uninsured women.¹⁰ When able to access care at all, these women often rely on safety net providers for reproductive, sexual, and maternal health care services.

THE NEED FOR A STRONG URBAN SAFETY NET

Urban safety net providers, such as Community Health Centers, Federally Qualified Health Centers, public hospitals, and local health departments, play a pivotal role in maintaining the health of urban communities.¹¹ On average, cities are home to the highest number of residents who live under the federal poverty level, as well as communities of color and residents who speak English less than “very well.”¹² The result is a culturally and linguistically diverse population

dependent upon safety net services.¹³ In 2007, 16.5% of the population in central cities lived below the federal poverty rate,ⁱⁱ and 18.5% of the population in central cities lacked health insurance.¹⁴ In comparison to national averages, communities of color have higher proportions of uninsured and underinsured residents, particularly among Hispanic communities, where 32.1% of the population was uninsured in 2007.¹⁵ Many recent immigrants do not qualify for

i Definitive data pertaining to the safety net has been difficult to compile given the many nebulous definitions of safety net provider and the complex interplay of socioeconomic factors that affect health outcomes of vulnerable and marginalized populations.

ii The U.S. Census Bureau uses a graduated scale and markedly conservative scale for poverty thresholds based on family size and composition. For example, in 2007 a family of four with two children could make no more than \$21,736 combined income per year to be classified as “in poverty,” while a single person under 65 years of age with no children had a threshold of \$10,787 per year. Geographic region is not taken into consideration.

Medicaid-covered family planning services, and 33.2% of the foreign-born population lacks health coverage.¹⁶ Additionally, suburban communities that traditionally have fewer safety net providers are increasingly impoverished and therefore dependent on the urban safety net for services.¹⁷ Urban centers are well positioned to serve this expansive population given their long history of providing services to vulnerable and diverse populations.¹⁸ However, the expansive urban safety net demand creates a large economic and health care burden that is disproportionately carried by cities.¹⁹

The need for safety net health services is growing. Between 1997 and 2007, the number of patients seen at safety net health centers increased by 95% and has currently reached

THE ROLE OF THE SAFETY NET FOR REPRODUCTIVE HEALTH SERVICES

At a national level, with approximately one-quarter of people of reproductive age uninsured and an even larger proportion among the impoverished, the demand for reproductive, sexual, and maternal health care from safety net providers, such as these local health departments, is overwhelming.²⁴ In the United States, 17.5 million women are in need of publicly supported contraception.²⁵ A critical source of support for these services is a federal program specifically for family planning, Title X of the Public Health Service Act. Funding from the Title X program supports a network of centers providing family planning counseling and services to women and men as well as preventive care such as cancer screenings. In 2006, 66% of the contraceptive visits to publicly funded centers occurred at a Title X-funded center.²⁶ Further, the

THE ROLE OF HOSPITALS

Throughout the United States, county governments run over 1,100 public hospitals.³⁰ For women who do not have access to a regular reproductive health provider, and for pregnant and birthing women, hospitals are a critical source of care. Without adequate preventive and primary care, emergency departments serve as “the safety net of the safety net,” providing acute care that often could have been avoided.³¹ Safety net hospitals account for 10% of all hospitals, yet cover nearly one-third of uninsured hospital stays.³² These hospitals, particularly urban public hospitals, tend to have higher percentages of patients suffering from chronic disease and Medicaid patients than privately insured patients.³³ This combination makes safety net hospital patients significantly more costly to treat overall and inhibits safety net hospitals from cross-subsidizing services for the uninsured via their insured patient load.³⁴ Additionally, many non-profit and private hospitals are attracting healthier Medicaid patients, leaving public and other primary safety net hospitals responsible for the sickest and most expensive Medicaid patients.³⁵ In light of the many barriers impeding the provision of quality safety net services, it is not surprising

over eighteen million people.²⁰ These health centers play a central role in ambulatory reproductive, sexual, and maternal health care for women.²¹ This is particularly true in cities, where nearly one-third of health center visits pertain to women’s health (ages 15–44).²² School-based health clinics and local health departments also assist in the provision of reproductive health care through family planning services, distribution of contraceptives and pregnancy tests, sexually transmitted infection screening, and educational outreach. However, Community Health Centers, school-based health centers, and local health departments often cannot meet many health care needs of the medically disenfranchised in their area due to budget and capacity constraints.²³

positive impact of Title X-funded services reaches far beyond contraception; the majority of women who receive care at a family planning center consider it their usual source of care, highlighting the critical role of Title X in supporting the safety net.²⁷

There are also 2,293 local health departments throughout the United States. Fifty-eight percent of these local health departments provide family planning services, 75% provide treatment for sexually transmitted diseases, and 42% provide prenatal care.²⁸ Local health departments located in larger areas are more likely to provide reproductive, sexual, and maternal health services.²⁹

that a 2003 study of metropolitan-area safety net providers found higher safety net demand correlates to worse health outcomes in areas such as late or no prenatal care, low birthweight, and preterm births.³⁶ Without sufficient funding and support, the safety net cannot facilitate access to quality reproductive, sexual, and maternal health care for the millions of medically underserved.³⁷

Demographic and fiscal disparities between health care providers result in safety net institutions that are financially vulnerable and unable to make quality improvements due to lack of capital, thus stifling growth and quality of service.³⁸ This cycle is exacerbated by recent pay-for-performance trends, where poor performance by safety net providers due to large indigent and uninsured health care burdens compromises their eligibility for financing.³⁹ Over a third of safety net hospitals have negative total income margins, and many public hospitals are either closing or merging with private entities.⁴⁰ Between 1996 and 2002, 16% of public city hospitals and 27% of public suburban hospitals closed, while only 11% of for-profit hospitals closed in both urban and suburban areas.⁴¹

Religious health care systems are playing a growing role in providing safety net health care as public hospitals are closing or merging with religiously affiliated groups. This growing presence of religiously affiliated hospitals reduces women's access to critical reproductive health care services, such as contraceptive services, abortion care, and infertility services and counseling. Furthermore, a notable proportion of private hospitals is owned by charitable religious organizations

(13%).⁴² For many hospitals, this affiliation limits the scope of available reproductive health services based on religious doctrine, despite the substantial government funding these hospitals receive through Medicaid and other public funds.⁴³ As an increasing number of public hospitals close, the proportion of religiously affiliated private hospitals expands, resulting in an immediate reproductive health deficit in the communities they serve.

HOW THE SAFETY NET IS FINANCED

Funding for safety net services consists of a patchwork of funding from federal, state, and local sources that varies in composition from state to state.⁴⁴ While state and federal decisions greatly affect the health care of urban residents, many safety net services are primarily locally run and funded at the county and city levels. Thirty-nine percent of unreimbursed safety net services are supported by state and local subsidies and twenty-eight states require that counties share in the cost of non-federal Medicaid expenses (43% of total Medicaid expenses).⁴⁵ Although most counties in most

states are able to levy taxes to help finance safety net services, their ability to do so is limited. Many local governments are left with a huge fiscal burden.⁴⁶ As urban fiscal conditions worsen, city budgets are increasingly unable to meet current needs and many are being forced to make across-the-board service cuts, including the closing of centers providing reproductive health services.⁴⁷ Growing numbers of uninsured and unemployed residents put further pressure on safety net services, stretching limited local funding even farther.⁴⁸



RECOMMENDATIONS TO PRESERVE SAFETY NET REPRODUCTIVE, SEXUAL, AND MATERNAL HEALTH CARE SERVICES

The steady loss of safety net services and the increased reliance by surrounding residents on the existing urban health care safety net unduly burden urban communities. Reproductive, sexual, and maternal health services are important components of safety net services. Despite the unfair burden placed on urban areas to serve those in need without adequate financing, local communities must continue to provide and share responsibility for these vital safety net services.

WE CALL ON LOCAL LEADERS TO PRESERVE SAFETY NET REPRODUCTIVE, SEXUAL, AND MATERNAL HEALTH CARE SERVICES BY:

Tackling the growing trend of safety net health center closures. As the need for safety net health services rises, closures continue among the centers that primarily serve low-income residents. These closures leave communities without vital health care services. Urban public hospitals are critical health care providers for poor urban residents as well as the growing numbers of suburban residents who are in need of safety net health services.

- We urge local leaders to stop the closure of urban public hospitals or, when that proves impossible, to address the subsequent increase in demand in surrounding Community Health Centers.

Addressing the impact that hospital mergers have on reducing access to reproductive health care. Local government and advocacy groups can work to reduce the negative impact that hospital mergers have on reproductive health services in the community.

- We urge local leaders to prevent hospital mergers that will limit access to reproductive health services.

Advocating for increases in state and federal funding for safety net services. As this brief outlines, local safety net services often rely on financial support from state and federal sources. In order to best provide services to urban underserved residents, state and federal funding must be increased.

- We urge local elected and public health officials to call on their state and federal governments to expand Medicaid coverage and increase funding for local safety net services such as Community Health Centers and Title X clinics.

LOCAL EXAMPLES:

- ❏ In **Prince George County, MD**, community advocates successfully prevented the sale of the county's public hospital system to a Catholic health care system, which would have resulted in the loss of abortion, HIV/AIDS counseling and other critical reproductive health care services.
- ❏ In **Seattle**, following announcements that due to budget shortfalls, King County would be forced to close family planning clinics, community advocates worked with the Metropolitan King County Council to successfully continue county support for family planning safety net services.

ENDNOTES

- 1 Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered* (Washington DC: National Academy of Sciences Press, 2000), <http://www.iom.edu/~lmedia/Files/Report%20Files/2000/Americas-Health-Care-Safety-Net/Insurance%20Safety%20Net%202000%20%20report%20brief.ashx> (accessed November 5, 2009).
- 2 Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2007* (Washington DC: U.S. Government Printing Office, August 2008), <http://www.census.gov/prod/2008pubs/p60-235.pdf> (accessed June 30, 2009).
- 3 U.S. Department of Labor, *The Employment Situation* (Washington DC: Bureau of Labor Statistics, U.S. Department of Labor, July 2009), <http://www.bls.gov/news.release/pdf/empisit.pdf> (accessed June 30, 2009).
- 4 National Association of Community Health Centers, *Primary Care Access: An Essential Building Block of Health Reform* (Bethesda: National Association of Community Health Centers, March 2009), <http://www.nachc.com/client/documents/pressreleases/PrimaryCareAccessRPT.pdf> (accessed June 30, 2009).
- 5 Jack Hadley and Peter Cunningham, "Availability of Safety Net Providers and Access to Care of Uninsured Persons," *Health Services Research* 39, no. 5 (October 2004): 1527-1546.
- 6 R.B. Gold and others, *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System* (New York: The Guttmacher Institute, 2009).
- 7 Sheila D. Rustgi, Michelle M. Doty, and Sara R. Collins, "Women at Risk: Why Many Women are Forgoing Needed Health Care," *Commonwealth Fund* 52, no. 1262 (New York: The Commonwealth Fund, 2009), http://www.commonwealthfund.org/~lmedia/Files/Publications/Issue%20Brief/2009/May/Women%20at%20Risk/PDF_1262_Rustgi_women_at_risk_issue_brief_Final.pdf (accessed June 4, 2009).
- 8 Alina Salganicoff, Usha R. Ranji, and Roberta Wyn, *Women and Health Care: A National Profile* (Menlo Park: Kaiser Family Foundation, July 2005), <http://www.kff.org/womenshealth/upload/Women-and-Health-Care-A-National-Profile-Key-Findings-from-the-Kaiser-Women-s-Health-Survey.pdf> (accessed June 4, 2009).
- 9 Cara James, Megan Thomas, and Marsha Lillie-Blanton, *Key Facts: Race, Ethnicity and Health Care* (Menlo Park: Kaiser Family Foundation, January 2007), <http://www.kff.org/minorityhealth/upload/6069-02.pdf> (accessed June 4, 2009).
- 10 National Institutes of Health, Office of the Director, *Women of Color Health Data Book: Adolescents to Seniors* (Bethesda: Department of Health and Human Services, National Institutes of Health, 2006), <http://orwh.od.nih.gov/pubs/WomenofColor2006.pdf> (accessed November 5, 2009).
- 11 John Billings and Robert M. Weinick, *Monitoring the Health Care Safety Net—Book 1: A Data Book for Metropolitan Areas* (Rockville: Agency for Healthcare Research and Quality, August 2003), <http://www.ahrq.gov/data/safetynet/databooks/databk1.pdf> (accessed June 30, 2009).
- 12 John Billings and Robert M. Weinick, *Monitoring the Health Care Safety Net—Book 1*.
- 13 John Billings and Robert M. Weinick, *Monitoring the Health Care Safety Net—Book 1*.
- 14 Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States*.
- 15 Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States*.
- 16 Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States*.
- 17 D.P. Andrulis and L.M. Duchon, "The Changing Landscape of Hospital Capacity in Large Cities and Suburbs: Implications for the Safety Net in Metropolitan America," *Journal of Urban Health: Bulletin of the New York Academy of Medicine* 84, no. 3 (May 2007): 400-414.
- 18 Dennis P. Andrulis, Hailey M. Reid, Lisa M. Duchon, *Quality of Life in the Nation's 100 Largest Cities and Their Suburbs: New and Continuing Challenges for Improving Health and Well Being* (Brooklyn: SUNY Downstate Medical Center, 2004), http://www.downstate.edu/urbansoc_healthdata/Urban%20Center%20Website/web%20design2/pdf%20files/report4pdfs/urbanreport4.pdf (accessed August 27, 2009).
- 19 John Billings and Robert M. Weinick, *Monitoring the Health Care Safety Net—Book 1; Families USA, America's Health Care Crisis: Cities on the Front Lines* (Washington DC: Families USA, 2008), <http://www.familiesusa.org/assets/pdfs/cities-on-the-front-lines.pdf> (accessed June 30, 2009).
- 20 Health Resources and Services Administration, *Bureau of Primary Health Care Section 330 Grantees Uniform Data System: National Rollup Report, Calendar Year 2007 Data* (Rockville: Health Resources and Services Administration, 2007), <ftp://ftp.hrsa.gov/bphc/pdf/uds/2007nationaluds.pdf> (accessed June 30, 2009); National Association of Community Health Centers, *Primary Care Access: An Essential Building Block of Health Reform*.
- 21 Health Resources and Services Administration, *Bureau of Primary Health Care Section 330 Grantees Uniform Data System*.
- 22 Health Resources and Services Administration, *Bureau of Primary Health Care Section 330 Grantees Uniform Data System*.
- 23 National Association of Community Health Centers, *The Safety Net on the Edge* (Bethesda: National Association of Community Health Centers, 2005), <http://www.chnwa.org/PolicyAdvocacy/ResearchAndReports/SafetyNetOnTheEdgeAugust2005.pdf> (accessed June 30, 2009); National Association of County & City Health Officials, *NACCHO Survey of Local Health Departments' Budget Cuts and Workforce Reductions* (Washington DC: National Association of County & City Health Officials, January 2009); Agency for Healthcare Research and Quality, *Serving the Uninsured: Safety-Net Hospitals, 2003* (Rockville: Agency for Healthcare Research and Quality, 2007), <http://www.ahrq.gov/data/hcup/factbk8/factbk8.pdf> (accessed June 30, 2009).
- 24 Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States*.

ENDNOTES

- 25 Rachel Benson Gold and others, *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System* (New York: Guttmacher Institute, 2009), <http://www.guttmacher.org/pubs/NextSteps.pdf> (accessed July 6, 2009).
- 26 The Guttmacher Institute, "Contraceptive Needs and Services, 2006" (New York: The Guttmacher Institute), <http://www.guttmacher.org/pubs/win/index.html> (accessed July 6, 2009).
- 27 J. Frost, U.S. *Women's Reliance on Publicly Funded Family Planning Clinics as their Usual Source of Medical Care*, paper presented at the 2008 Research Conference on the National Survey of Family Growth (Hyattsville: Oct. 16 and 17, 2008).
- 28 Carolyn J. Leep, "2005 National Profile of Local Health Departments," (Washington, D.C.: National Association of County & City Health Officials, 2006), http://www.naccho.org/topics/infrastructure/profile/upload/NACCHO_report_final_000.pdf (accessed July 28, 2009).
- 29 Carolyn J. Leep, "2005 National Profile of Local Health Departments."
- 30 Carolyn J. Leep, "2005 National Profile of Local Health Departments."
- 31 Health Resources and Services Administration, *Primary Care Access: An Essential Building Block of Health Reform*.
- 32 Agency for Healthcare Research and Quality, *Serving the Uninsured: Safety-Net Hospitals, 2003*.
- 33 Dennis P. Andrulis and Lisa M. Duchon, "Hospital Care in the 100 Largest Cities and Their Suburbs, 1996-2002: Implications for the Future of the Hospital Safety Net in Metropolitan America," *The Social and Health Landscape of Urban and Suburban America Report Series* (Brooklyn NY: SUNY Downstate Medical Center, August 2005), <http://www.rwjf.org/files/research/Andrulis%20Hospitals%20Report-final.pdf> (accessed June 30, 2009); Agency for Healthcare Research and Quality, *Serving the Uninsured: Safety-Net Hospitals, 2003*.
- 34 Agency for Healthcare Research and Quality, *Serving the Uninsured: Safety-Net Hospitals, 2003*.
- 35 Dennis P. Andrulis and Lisa M. Duchon, "Hospital Care in the 100 Largest Cities and Their Suburbs."
- 36 John Billings and Robert M. Weinick, *Monitoring the Health Care Safety Net—Book 1*.
- 37 National Association of Counties, *Counties' Role in Health Care Delivery and Financing* (Washington DC: National Association of Counties, July 2007).
- 38 National Association of Community Health Centers, *Primary Care Access: An Essential Building Block of Health Reform*; Marion E. Lewin and Raymond J. Baxter, "America's Health Care Safety Net: Revisiting the 2000 IOM Report," *Health Affairs* 26, no. 5 (September/October 2007): 1490-1494.
- 39 R.M. Werner, E. Goldman, and R.M. Dudley, "Comparison of Change in Quality of Care Between Safety-Net and Non-Safety-Net Hospitals," *Journal of the American Medical Association* 299, no. 18 (2008): 2180-2187.
- 40 Agency for Healthcare Research and Quality, *Serving the Uninsured: Safety-Net Hospitals, 2003; The Safety Net on the Edge*; Marion E. Lewin and Raymond J. Baxter, "America's Health Care Safety Net": 1490-1494; Dennis P. Andrulis and Lisa M. Duchon, "Hospital Care in the 100 Largest Cities and Their Suburbs."
- 41 Dennis P. Andrulis and Lisa M. Duchon, "Hospital Care in the 100 Largest Cities and Their Suburbs."
- 42 Lois Uttley and Ronnie Pawelko, *No Strings Attached: Public Funding of Religiously-Sponsored Hospitals in the United States* (New York: MergerWatch Project, 2002), http://www.mergerwatch.org/pdfs/lbp_no_strings.pdf (accessed June 29, 2009).
- 43 Lois Uttley and Ronnie Pawelko, *No Strings Attached*.
- 44 National Association of Counties, *Counties' Role in Health Care Delivery and Financing*.
- 45 National Association of Counties, *Counties' Role in Health Care Delivery and Financing*.
- 46 National Association of Counties, *Counties' Role in Health Care Delivery and Financing*.
- 47 Chris Hoene, "Fiscal Outlook for Cities Worsens in 2009," *Research Brief on America's Cities* (Washington DC: February 2009), http://www.nlc.org/ASSETS/1F73FD6DD09249DB9B2FD014AA4D9C16/CFC_InterimSurvey_09.pdf (accessed June 30, 2009); Anecdotal reports from Urban Initiative participants.
- 48 John Billings and Robert M. Weinick, *Monitoring the Health Care Safety Net—Book ; America's Health Care Crisis*.



The Urban Initiative for Reproductive Health is a program of the National Institute for Reproductive Health (National Institute).

The National Institute is an innovation institute for state and local organizations working on reproductive health issues. We offer strategic guidance, hands-on support and funding to help state and local leaders remove barriers to health care, win public battles and change public policies. Together, we are helping women in communities across the country gain access to the full range of quality reproductive health care options, the freedom to exercise their reproductive rights and the opportunity to have healthy pregnancies.

www.UrbanInitiative.org
www.nirhealth.org



NATIONAL
INSTITUTE FOR
REPRODUCTIVE
HEALTH

470 Park Avenue South, 7th Floor South, New York NY 10016
P: 212-343-2031, F: 212-343-0119

December 2009