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Perspectives

The Mission of Safety Net Hospitals: Charity or Equity?

Thea James

ABSTRACT

The traditional mission of safety net hospitals has been charity, providing the best healthcare for all individuals no matter their ability to pay. The focus has been on vulnerable populations that are low-income, uninsured, and other upstream circumstances that manifest downstream as poor health, poor health outcomes, and repeated high-cost interventions that fail to break cycles of perpetual health instability. Safety net hospitals are committed to serving their populations, even if only temporarily, through provision of subsidies and filling gaps that exist in patients' lives. These interventions do not lead to the elimination of gaps, hence cyclical health instability persists. It is a new day in healthcare and what it means for people to be well. The focus is on improving health outcomes by addressing root causes of health instability such as unstable housing, income, education, and access to affordable healthy foods. This gives us pause to reflect on the traditional mission of safety net hospitals and the impact of charity in isolation. Are safety net hospitals missing an opportunity to mitigate and eliminate perpetual health instability? Can they shift the paradigm of healthcare for vulnerable populations to alter their quality-of-life course? To move forward, safety net hospitals have to change their mind set and existing narratives about what is possible for vulnerable populations to achieve. These historic giants in healthcare have an opportunity to use their assets and employ a methodology of disruption and innovation to shift the mission of safety net healthcare from charity to equity.

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Three years ago I had the privilege to become the first Vice President of Mission in a nonreligious, safety-net, academic medical center. Unknown to me, Vice President of Mission is traditionally a role found in faith-based healthcare organizations. Prior to entering the C-suite, my previous 24 years were spent as a practicing emergency medicine physician at my present medical center, where a majority of the patients represent underserved populations and are socioeconomically living below the federal poverty line. Our patients and their families taught me everything I know about what they say they need to be well and to thrive. Throughout the years my experiences partnering with them has shaped my perspective on the notion of "mission." Although my role was new to me and to our organization, I felt I had been preparing for it for years and somehow felt a natural connection to it.

I moved into a quiet new office located away from the constant chatter, action, multi-tasking, and controlled chaos of the emergency department. I thought about how fortunate I was to reach this point in my career and have a new opportunity to learn, to be challenged, to make mistakes, and to join the team of leaders who ran our healthcare system. My hope and goal was to be able to contribute and add value to our organization, our partners, communities we serve, our patients, and my colleagues. I en-

visioned us shifting into another gear, moving beyond the *status quo* approach of providing healthcare for vulnerable populations—charity. I knew I saw things through an alternative lens. I also knew any vision would have to be clearly communicated as something that would contribute value to our bottom line.

From my view of my new role, I questioned what mission meant and wondered whether we were meeting our pledge. Having spent my entire career in a safety-net healthcare system I questioned the practice of *charity* and its true impact on vulnerable populations, especially as it relates to our mission. I asked myself whether charity would ever enable our patients to step out of the "line of need" and move to independence and thriving—versus barely surviving. I questioned how charity might be influencing where we set the bar for our mission, for our healthcare outcomes, and our achievement goals. I questioned whether our existing healthcare intervention model for a vulnerable patient population might cause us to inadvertently miss new opportunities to enhance financial performance. Could we move beyond the *status quo* of how healthcare systems care for vulnerable populations? Finally, I wondered whether we could shift our entire healthcare delivery paradigm upstream from charity to equity?[1] That shift would be a challenge; the greatest challenge would be changing mind set about what is possible for vulnerable populations and for us as a healthcare organization to achieve. We are a nimble, creative, and bold organization, but the narrative about what is possible for vulnerable populations to achieve is an amalgamation of hard-wired assumptions.

Visitors touring our healthcare campus often tell us that, unsolicited, employees throughout our campus say they work here because of the mission. There are other employees who, when asked in passing, "How are you doing?" respond with "Saving lives." I assume that for my colleagues the meaning of mission is subjective, but their individual interpretations are probably more similar than different. I think what most employees mean is they have chosen to work in a healthcare system where the majority of patients are overwhelmingly socio-economically vulnerable, ethnically diverse, minorities, and many are immigrants; they want to help. My colleagues are committed to serving this population in the best way they know how, even if only temporarily filling existing gaps in the lives of patients. It is certainly understandable given our healthcare system's rich history.

In 1864 our organization opened its doors as the first public hospital established in the United States. The hospital was "intended for the use and comfort of poor patients, to whom medical care will be provided at the expense of the city, and . . . to provide accommodations and medical treatment to others, who do not wish to be regarded as dependent on public charity." Today, that mission has not changed. But paying attention while working in the emergency department provided me with a glimpse into human nature, the human condition, and all of what constitutes life. It taught me to listen and to learn what matters to people. I learned that our treatment plans cannot compete with people having to prioritize the basic necessities of survival over their health—no matter how much we "help" them. As humans with limited resources, when patients have to make hard choices between feeding a family, maintaining unstable shelter, keeping the lights on, and purchasing a prescription, health and healthcare will always be ranked secondary to survival. We have to be mindful, intelligent, and informed to avoid the mistake of passing judgment on the downstream medical consequences of patients' lack of options.

It is a new day in healthcare and what it means for people to be well. We have to be thoughtful and decide: Are we going to anchor vulnerable populations with opportunities to thrive? Or will we use charity and anchor them in place with no way out? "Anchoring" is a double entendre.

Today the medical approach to wellness is not repeatedly treating acute and chronic unstable disease in isolation, because these are downstream consequences of root causes upstream like housing, income, education, and healthy affordable food. Our mission should be targeted there, upstream, to mitigate and eliminate those gaps with interventions that alter the quality of our patients' life course.[2] For example, going forward we will not summarily provide access to temporary food subsidies to address food insecurity. Our operations intervention model will include access to living-wage-paying employment to eliminate the gap. To sustain our interventions we have to go farther upstream with our mission outside our hospital walls.[3] We are developing partnerships with multisector industries and other medical centers to leverage our collective resources to disrupt structural barriers to thriving and stable health that exist in communities.[4] We aim to transform communities by creating inclusive stable economic solutions that lead to healthy and vibrant communities.[5]

CONCLUSION

Understanding the root causes of chronic health instability and socioeconomic vulnerability is necessary to eliminate them. From my perspective this is our mission. We need critical insight to eliminate drivers of non-adherence, cyclical poor health outcomes, excessive healthcare utilization, and high costs. Comprehension of the roots of socioeconomic vulnerability and the structural barriers that create it is an invaluable complement to compassion. This is especially true when cynicism and compassion fatigue sometimes overwhelm best practices. Humans respond to kindness and sincerity, even in their worst state. In fact their worst state is our greatest opportunity to alter their perspective on what is possible. I begin by asking patients: "What would it take for this to never happen again?" Their responses are most often not insurmountable and are in fact logical and reasonable.

In my new role as VP of Mission I imagined an opportunity to re-examine our mission. I know we are nimble, creative, and bold and can shift the mission paradigm from charity to equity, and gradually integrate it into our business model to have social impact, a business impact, and to show a return on our investment. I thought we should seize the moment of a national focus on the determinants of health and leverage accompanying funding supports to create infrastructure to achieve a higher mission that is mutually beneficial to our patients, surrounding communities, and our healthcare system. We have an opportunity to shift from charity to equity, a healthcare paradigm shift for the long term. I will describe our work and specific programs in more detail in a future article in *The Journal of Clinical Ethics*.

NOTES

1. M. Marmot and J.J. Allen, "Social Determinants of Health Equity," *American Journal of Public Health* 104 (September 2014): S517-9.

2. D.R. Williams, M.V. Costa, A.O. Odunlami, and S.A. Mohammed, "Moving Upstream: How Interventions that Address the Social Determinants of Health can Improve Health and Reduce Disparities," *Journal of Public Health Management Practice* 14 (November 2008): 8-17.

3. R. Hacke, "Improving Community Health by Strengthening Community Investment," *Roles for Hospitals and Health Systems,* March 2017, *https://www.rwjf.org/content/dam/farm/reports/reports/2017/rwjf435716.*

4. G.N. Graham, "Why Your ZIP Code Matters More Than Your Genetic Code: Promoting Healthy Outcomes from Mother to Child," *Breastfeeding Medicine* 11 (October 2016): 396-7; The Fair Housing Center of Greater Boston, "Historical Shift From Explicit to Implicit Policies Affecting Housing Segregation in Eastern Massachusetts: 1934-1968: FHA Mortgage Insurance Requirements Utilize Redlining," *http://www.bostonfairhousing.org/timeline/1934-1968-FHA-Redlining.html.*

5. *https://www.healthcareanchor.network.*