

# GRANT WATCH REPORT

## Is There A (Volunteer) Doctor In The House? Free Clinics And Volunteer Physician Referral Networks In The United States

What was learned from a W.K. Kellogg Foundation–funded effort to understand the role of volunteerism in health care for the underserved.

by **Stephen L. Isaacs and Paul Jellinek**

**ABSTRACT:** Although community health centers and public hospitals are the most visible safety-net providers, physicians in private practice are the main source of care for the uninsured and Medicaid enrollees. Yet the number of these physicians providing free care is declining, even as the need for their services increases. One promising strategy for halting the decline is to strengthen and increase volunteer health care programs: free clinics and physician-referral networks. This report reviews the state of these programs and suggests ways to improve them. Given the limits of volunteerism, the authors conclude that only national health insurance will solve the problem of the uninsured. [*Health Affairs* 26, no. 3 (2007): 871–876; 10.1377/hlthaff.26.3.871]

THE CENTER FOR STUDYING Health System Change reported recently that from 1996–97 to 2004–05, the proportion of doctors in the United States providing charity care dropped eight percentage points, from 76 percent to 68 percent.<sup>1</sup> Why does this matter? First, the number of people who need charity care has been rising rapidly. Between 2000 and 2005, more than seventeen million people either lost their health insurance or signed up for Medicaid.<sup>2</sup> The upshot is that today more than one in four Americans—roughly eighty-eight million people—either are uninsured or receive Medicaid coverage.<sup>3</sup> Second, contrary to common perceptions, doctors in private practice are the most important source of care for this rapidly grow-

ing part of the population: Roughly four out of five patients who are uninsured or Medicaid recipients receive their primary care in a physician's office.<sup>4</sup> The reason for this is the sheer number (some 720,000) of practicing physicians.<sup>5</sup> Although each may see only a few uninsured patients, because there are so many practitioners, the aggregate number of such patients is large.<sup>6</sup> This means that any decline in private doctors' willingness or capacity to provide charity care is likely to affect the safety net—at the very time it is stretched by the influx of new uninsured and Medicaid patients.<sup>7</sup>

Why are physicians less likely now to provide charity care than they were ten years ago? Mostly, it appears, because their practices are

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being squeezed by steadily declining insurance reimbursement on the one hand and sharply rising operating costs on the other.<sup>8</sup> These pressures make it increasingly difficult to see patients who cannot afford to pay—or, in the case of Medicaid, patients for whom payment rates are often inadequate.<sup>9</sup>

One development might help slow down, if not reverse, the decline in charity care by doctors: the emergence of free clinics and networks of physicians willing to treat patients in their offices for free. Essentially, free clinics and volunteer referral networks make it easier for physicians to provide free care by screening patients, handling paperwork, helping patients get lab tests and medications, arranging for specialty care, and seeing that the burden of uncompensated care is evenly distributed in a community.

### Volunteer Health Care Programs

With funding from the W.K. Kellogg Foundation, which sought to understand the role of volunteerism in medical care for underserved people, from April 2005 to February 2006 we conducted a comprehensive literature review; interviewed experts in the field and staff and board members of national, regional, and state volunteer health care organizations; and visited twenty-one community-based volunteer health care programs across the country, selected to include both large and small sites located in big cities, suburbs, and rural areas.<sup>10</sup> Not surprisingly, there was great variety among the programs. However, they had one thing in common: They were all extremely busy. This paper describes some of what we learned from the Kellogg project.

Volunteer health care programs are just one component of the safety net. About 1,000 federally qualified health centers (FQHCs), using paid staff (sometimes supplemented by volunteers), serve fourteen million people a year, of whom 40 percent are uninsured; the nation's 1,300 public hospitals serve a disproportionate number of uninsured patients, perhaps three

to four million; and other hospitals also serve as a source of care for poor and uninsured people, as do many of the nation's 3,000 local health departments.<sup>11</sup>

Two kinds of volunteer organizations provide health care to the poor and uninsured: free clinics and volunteer referral networks. Free clinics are private, nonprofit, community-based organizations that provide medical, dental, pharmaceutical, or mental health services (or some combination) at little or no cost

to low-income, uninsured, or underinsured people.<sup>12</sup> Instead of serving patients in a clinic, referral networks refer patients needing specialty care and, in some cases, primary care, to office-based physicians who have agreed

to see patients for little or no cost.

■ **Free clinics.** In 2003 there were 1,718 free clinics in forty-nine states and the District of Columbia. Concentrated in the most populous states, they provided medical care to 2.5 million people that year.<sup>13</sup> They offer a wide range of primary care and, to a lesser extent, specialty care to a mostly uninsured clientele.<sup>14</sup> Free clinics range from the small and struggling Presbyterian Health Clinic in Coldwater, Michigan, which operates two to three hours a day, two days a week, and is run out of a church basement by a nurse (whose husband is the pastor) and a handful of volunteers, to the large and comparatively prosperous Venice Family Clinic, where 250 permanent staff members and more than 2,000 volunteers offer primary and specialty care to 22,000 patients a year in western Los Angeles, California.

■ **Referral networks.** In contrast, referral networks enlist specialists who agree to treat uninsured patients in their offices for no or minimal cost. Patients are often referred by community health centers or primary health clinics in the area. Under this model, network coordinators schedule patients' visits to specialists, arrange for transportation and translation where needed, and handle the paperwork.

Project Access, located in Buncombe

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County, North Carolina, pioneered the referral model. It recruited 630 of the county's 700 physicians (70 percent of the volunteers are specialists) to provide free care to referred patients. At least fifty locations throughout the country have replicated the model. Another approach, taken by San Francisco's Operation Access, in California, is to recruit volunteer surgeons who provide free nonemergency surgery, such as hernia repair, tonsillectomy, and cataract removal, for the working poor—people who earn too much to qualify for Medicaid and too little to afford health insurance.

### Characteristics Of Volunteer Programs

Although there is great variety among volunteer health care programs, they share many common characteristics.

■ **Provide care at little or no cost.** Most volunteer health care programs offer free services. Some, however, charge a small fee or ask patients for a donation, usually in the \$5 to \$10 range.

■ **Serve uninsured patients.** Unlike FQHCs, where only 40 percent of patients are uninsured, volunteer health care programs provide care mainly to uninsured patients.<sup>15</sup> A 2004 survey of midwestern free clinics found that 93 percent of their patients did not have health insurance.<sup>16</sup>

■ **Rely on volunteers.** Although most volunteer programs have some paid staff, their reliance on volunteers at all levels—from receptionists to physicians—distinguishes them from community health centers and other safety-net facilities, where paid staff members deliver services. Typically, physicians in volunteer clinics donate one to four half-day sessions a month. Physicians in private offices volunteer to see a few patients a month.

■ **Offer a variety of services.** Even the smallest free clinics offer a range of primary care services, health education for adults, and prescription drugs. Many provide specialty

services such as dental care, mental health care, substance abuse treatment, vision care, x-rays, and laboratory analyses.

■ **Connect to the community.** Nearly every free clinic and referral network grew out of the efforts of one or more committed physicians or other health professionals who tapped their colleagues' idealism and persuaded them to volunteer. These programs depend on community volunteers to provide services and serve on their boards.

### ■ Struggle financially.

Many volunteer programs are in a precarious financial position, relying on community resources such as United Way, hospitals, faith-based organizations, and individual contributions to keep them alive. In our survey, staff members of free clinics and referral networks noted, though, that businesses and

hospitals sometimes contribute little financially to the volunteer organizations whose free medical services save them money.

Large national and regional foundations have not generally supported volunteer health care programs. There are two exceptions. The Robert Wood Johnson Foundation Reach Out Program, authorized in 1993, financed volunteer programs in twenty-four states and the District of Columbia.<sup>17</sup> Also, the Kellogg Foundation supported the association of free clinics in the Great Lakes region and, through the foundation's Community Voices program, a free clinic for men—the first such clinic in the United States.

### Coordinating And Advocacy Organizations

Twenty-three states and two regions—the Great Lakes and the West—have formed associations of free clinics.<sup>18</sup> These state and regional organizations support and advocate for their members and also keep them up to date on policy issues, provide technical support, organize meetings, identify funding sources, and form cooperatives to enable member clinics to

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obtain discounted medications.

The National Association of Free Clinics is a membership group consisting of roughly 275 free clinics and state associations. It serves as the Washington, D.C.-based advocate for free clinics, a source of technical assistance and a resource bank, and a clearinghouse linking members to drug-donation programs. A second national organization, Volunteers in Health Care, had served as a communications hub for volunteer programs since 1994. Its Web-based program, RxAssist, made it easier for volunteer programs to purchase discounted drugs. It closed in 2006 as a result of a lack of funds.

### Challenges For Volunteer Programs

The challenges can be grouped into three general categories: external, service-related, and organizational.

■ **External challenges.** *Growing demand for services.* The rising number of uninsured Americans, concentrated among working-age adults ages 18–64 (the age group most frequently seen by volunteer health care programs), puts considerable pressure on these programs. Between 2004 and 2006, for example, the number of patients cared for by the Free Medical Clinic of Cleveland increased 20 percent. Many of the clinic's new patients are the “working poor”—people who are employed but lack health insurance or who were recently laid off.

*Increasing burden of chronic care.* Volunteer health care programs have seen an increase in the number of people with chronic diseases, especially diabetes, we learned. The Charlottesville (Virginia) Free Clinic, for example, reported that in its twelve years of operation, patient visits for chronic illnesses increased from less than 15 percent to more than 70 percent.<sup>19</sup> Controlling chronic diseases presents special challenges, often requiring adoption of chronic care models or disease management programs that rely on education, self-medication, disease registries, and teamwork among

providers and patients.

*Increasing economic strain on providers.* Reduced payment rates by Medicare, Medicaid, and managed care plans, together with increased operating costs, has forced many physicians to see more insured patients, leaving them less time to volunteer and see uninsured patients.

*Changing patient mix.* A striking aspect of volunteer health care programs is the large number of immigrants they serve. At the Health Care Network in Racine, Wisconsin, for example, the proportion of Hispanic patients rose from less than 1 percent in the late 1980s to 50 percent in 2006. Volunteer programs in Chicago, Miami, Hilton Head (South Carolina), Cotati (California), and Red Bank (New Jersey) now have patient populations that are

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more than 50 percent Hispanic. In Omaha, the Hope Medical Outreach Coalition serves many Sudanese, Somali, and Eritrean patients. This growing diversity poses language and cultural sensitivity challenges, not to mention the discomfort that some volunteers feel in providing care to undocumented immigrants.

■ **Service-related challenges.** *Specialty care.* Lack of access to specialists is a problem, especially in rural communities. Although the needed specialties vary from place to place, psychiatrists, orthopedists, urologists, rheumatologists, and dentists are often in short supply.

*Medicines.* Obtaining medications is another challenge. Most programs rely on some combination of donated samples, discounted bulk purchases, generics, the federal government's 340B discount drug program, and, especially, private drug companies' patient assistance programs (PAPs).<sup>20</sup> Navigating the different and often changing eligibility requirements and application procedures for PAPs is time-consuming, often requiring at least one full-time staff person.

*Malpractice coverage.* Lack of malpractice coverage is perceived as a serious impediment to attracting volunteers. The reality might be

somewhat more complex, because a variety of mechanisms provide protection for volunteer physicians and other health care professionals. At the state level, forty-three states and the District of Columbia have enacted charitable immunity laws, which either raise the negligence standard from simple negligence to gross negligence or indemnify volunteers as if they were state employees.<sup>21</sup> At the federal level, the Volunteer Protection Act of 1997 offers some protection for health care volunteers by raising the malpractice standard from simple negligence to gross negligence and by restricting the amount of punitive damages that can be awarded, and the Federal Tort Claims Act (FTCA) was expanded in 1996 to cover volunteers serving at free clinics. It became effective in 2004 when the U.S. Department of Health and Human Services issued implementing regulations. Under the FTCA a patient alleging injuries by a volunteer at a free clinic sues the federal government rather than the volunteer. Because of the onerous process of obtaining coverage under the FTCA, only a small number of free clinics have obtained such coverage.<sup>22</sup>

■ **Organizational challenges.** For the most part, free clinics and referral networks live hand to mouth. Whatever the size of their budgets, fund raising occupies a disproportionate amount of executive directors' time. Also, although most programs appear to be well integrated into their communities, their leaders have little interaction with directors of volunteer programs in other communities and are often unaware of the ways in which other programs have addressed similar problems. Apart from the practical problems associated with isolation, leaders lack the value of peer support in what is often a stressful job.

**E**VEN AS THE NUMBER of uninsured Americans rises steadily, straining the safety net, Congress appears unlikely to offer a national solution in the near term.<sup>23</sup> The main providers of safety-net services—private physicians—face mounting time and financial pressures that restrict their ability to volunteer. Given the continuing increase in

need and the vital role of physicians in meeting that need, finding ways to halt, and, it is hoped, reverse, the decline should be a high priority.

One strategy for increasing volunteer care by physicians (and other health professionals) is to fortify volunteer health care programs. Specific actions—such as getting seed grants, improved communication and interaction within the field, leadership development, advocacy, and stronger national leadership—should help strengthen them. Even so, there are limits to what volunteer programs can do. Although nearly 1,800 free clinics and volunteer referral networks that serve about 2.5 million people a year might sound like many providers, they cover only a small fraction of the need. Thus, although volunteer organizations can make an important contribution to the care of poor and uninsured people in the short run, their ultimate reach (and, indeed, the reach of all the institutions providing safety-net care) is limited, and only national health insurance will totally solve the problem.

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*The authors gratefully acknowledge the financial support of the W.K. Kellogg Foundation.*

**NOTES**

1. P.J. Cunningham and J.H. May, "A Growing Hole in the Safety Net: Physician Charity Care Declines Again," Health Tracking Report no. 13 (Washington: Center for Studying Health System Change, March 2006).
2. Authors' calculations based on data from Kaiser Commission on Medicaid and the Uninsured, "Covering the Uninsured: Growing Need, Strained Resources," Fact Sheet, January 2007, <http://www.kff.org/uninsured/upload/7429-02.pdf> (accessed 15 March 2007); and Kaiser Commission, *Medicaid Enrollment in Fifty States: June 2005 Data Update*, December 2006, Figure 1, <http://www.kff.org/medicaid/upload/7606.pdf> (accessed 15 March 2007).
3. Ibid.
4. C.B. Forrest and E.M. Whelan, "Primary Care Safety-Net Delivery Sites in the United States: A Comparison of Community Health Centers, Hospital Outpatient Departments, and Physicians' Offices," *Journal of the American Medical Association* 284, no. 16 (2000): 2077–2083.
5. Authors' calculation derived from American

- Medical Association, *Physician Characteristics and Distribution in the U.S.: 2007 Edition* (Chicago: AMA, 2007).
6. G. Fairbrother et al., "Care for the Uninsured in General Internists' Private Offices," *Health Affairs* 22, no. 6 (2003): 217–224.
  7. J. Hadley et al., *Federal Spending on the Health Care Safety Net from 2001–2004: Has Spending Kept Pace with the Growth in the Uninsured?* November 2005, <http://www.kff.org/uninsured/7425.cfm> (accessed 5 February 2007).
  8. M.C. Reed, P.J. Cunningham, and J. Stoddard, "Physicians Pulling Back from Charity Care," Issue Brief no. 42 (Washington: HSC, August 2001).
  9. See E. Salinsky, "Necessary but Not Sufficient? Physician Volunteerism and the Health Care Safety Net," Background Paper (Washington: National Health Policy Forum, 10 March 2004).
  10. The twenty-one volunteer health care programs were located in California (Cotati, San Francisco, and Venice); Florida (Miami); Illinois (Chicago); Kansas (Wichita); Michigan (Coldwater, Grand Rapids, and Kalamazoo); Nebraska (Omaha); New Hampshire (Exeter); New Jersey (Red Bank); North Carolina (Asheville); Ohio (Cleveland and Lakewood); South Carolina (Hilton Head); Tennessee (Knoxville, Maryville, and Sevierville); West Virginia (Charleston); and Wisconsin (Racine).
  11. Donald Weaver, assistant surgeon general and deputy associate administrator for primary health care, Health Resources and Services Administration, "HRSA's Health Center Program: Overview" (slides), personal communication, 21 March 2007; authors' estimates of the number of public hospital patients based on information in O. Zaman, E. Lukens, and L. Cummings, *America's Public Hospitals and Health Systems, 2004: Results of the Annual NAPH Hospital Characteristics Survey* (Washington: National Association of Public Hospitals and Health Systems, 2006); and American Hospital Association, "Uncompensated Hospital Care Cost Fact Sheet," October 2006, <http://www.aha.org/aha/content/2006/pdf/uncompensatedcarefs2006.pdf> (accessed 12 February 2007). The nation's hospitals provided \$28.8 billion in uncompensated care; the AHA did not state the number of patients this covered.
  12. See the National Association of Free Clinics home page, <http://www.freeclinics.us>.
  13. HRSA, *Report to Congress: A Review of the Free Clinics Network* (Rockville, Md.: HRSA, 2005).
  14. Authors' estimate of the number of patients served is based on information provided in *ibid.*
  15. Weaver, HRSA, "HRSA's Health Center Program"; and S. Rosenbaum and P. Shin, "Health Centers as Safety Net Providers: An Overview and Assessment of Medicaid's Role," Figure 6, May 2003, <http://www.kff.org/medicaid/4113-index.cfm> (accessed 26 March 2007).
  16. S. Geller, B.M. Taylor, and H.D. Scott, "Free Clinics Helping to Patch the Safety Net," *Journal of Health Care for the Poor and Underserved* 15, no. 1 (2004): 42–51.
  17. See H.D. Scott et al., "Physicians Helping the Underserved: The Reach Out Program," *Journal of the American Medical Association* 283, no. 1 (2000): 99–104.
  18. Additionally, the Volunteers in Medicine Institute serves as a resource for clinics that replicate the approach of Volunteers in Medicine in Hilton Head, South Carolina. The American Project Access Network plays a similar role for clinics that adopt the approach of Project Access, located in Asheville, North Carolina.
  19. M.M. Nadkarni and J.T. Philbrick, "Free Clinics and the Uninsured: The Increasing Demands of Chronic Illness," *Journal of Health Care for the Poor and Underserved* 14, no. 2 (2003): 165–174.
  20. HRSA, "Welcome to Pharmacy Services Support Center," <http://pssc.aphanet.org> (accessed 12 February 2007).
  21. P.A. Hattis, "Overcoming Barriers to Physician Volunteerism: Summary of State Laws Providing Reduced Malpractice Liability Exposure for Clinician Volunteers," *University of Illinois Law Review* 2004, no. 1 (2004): 167–181.
  22. HRSA's *Report to Congress* found that fifteen clinics had obtained coverage as of 2003. As of March 2007, seventy-five clinics had obtained coverage under the Federal Tort Claims Act. Martin W. Hiller, founding board member, National Association of Free Clinics, personal communication, 16 March 2007.
  23. D. Solomon and D. Wessel, "Health-Insurance Gap Surges as Political Issue," *Wall Street Journal*, 19 January 2007; and S.G. Stolberg and R. Pear, "Bush Urges Tax to Help Cover the Uninsured," *New York Times*, 21 January 2007.