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Necessary but Not Sufficient? Physician Volunteerism and the Health Care Safety Net

Eileen Salinsky, *Principal Research Associate*

OVERVIEW — *This paper examines the role of physician-sponsored charity care in meeting the health care needs of the uninsured. The paper provides an overview of current charity care levels by medical specialties and geographic regions, discusses limitations in available data, and describes the settings in which charity care is provided. The paper also summarizes the factors that motivate physicians to provide volunteer services, as well as the barriers that hinder volunteer activities, including malpractice insurance concerns. Also discussed are a range of public policies, both existing and considered, that support volunteer activities, with a particular emphasis on the expansion of Federal Tort Claims Act coverage to physicians who volunteer in free clinics.*

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National Health Policy Forum
 2131 K Street NW, Suite 500
 Washington DC 20037

202/872-1390
 202/862-9837 [fax]
 nhpf@gwu.edu [e-mail]
 www.nhpf.org [web]

Judith Miller Jones
Director

Sally Coberly
Deputy Director

Michele Black
Publications Director

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Necessary but Not Sufficient?: Physician Volunteerism and the Health Care Safety Net

Rising uninsurance rates, combined with lingering budgetary pressures at both state and federal levels, have led policymakers to explore new approaches to improving access to health care services and responding to unmet health care needs. As concerns related to the feasibility and affordability of existing insurance models have grown, novel solutions are being considered, including “front-loaded” health plans that limit coverage to primary and preventive services. Incorporated into many of these emerging approaches is a renewed focus on the role of health care providers’ charitable activities and responsibilities.

The obligation to provide charity care to the poor has historically been an important part of physicians’ professional ethos. Since the mid-1800s the American Medical Association (AMA) has encouraged physicians to provide free services to the poor through the organization’s *Code of Medical Ethics*. However, as health care has evolved into a multibillion-dollar industry, mediated by public- and private-sector third-party payers and regulatory bodies, professional standards related to charity care have also changed over time. While the duty of charity care was originally housed in the code’s section on “duties of the profession to the public,” it has since shifted to one focused on compensation. The current *Code of Medical Ethics* retains the injunction to provide free care to the impoverished but clearly specifies that endowed institutions, such as hospitals and health insurers, have no claims upon physicians for unremunerated services.¹

This shift reflects growing tensions over who should bear the financial burden of providing care to the poor and uninsured. While there is consensus that physicians who volunteer their professional services are admirable and should be encouraged and recognized, considerable debate surrounds the appropriate role of volunteerism in the health care safety net. Some, believing that charity care should serve as the cornerstone of efforts to address the health needs of the poor and uninsured, advocate leveraging both private-sector charity and public support and marshaling public policies to facilitate volunteer efforts.

Others contend that the health care needs of the poor and uninsured are a fundamental societal responsibility that are too complex for fragmented, volunteer-based solutions. They worry that an undue reliance on volunteerism may detract from efforts to both increase public funding for organized safety net services and achieve universal health care insurance

coverage. Many others fall somewhere between these extremes and view volunteer-based efforts as a practical, immediate response to the complex problem of uninsurance that is unlikely to be resolved in the short term.

SIZING UP CHARITY CARE: BIGGER THAN A BREAD BOX

While opinions differ regarding long-term strategies for meeting the health care needs of the medically indigent, the present import of physician-sponsored care is clear. Private-practice physicians currently represent the dominant source of ambulatory care for the uninsured. In 1994, an estimated 82 percent of primary care visits by the uninsured occurred in physician offices, compared to 10 percent in community health centers and 8 percent in hospital outpatient departments.² Although it is unclear what proportion of these private-practice-based visits was paid for out-of-pocket by uninsured persons, the willingness of private physicians to treat uninsured persons is obviously critical to the viability of the safety net. Reliance on private practice-based physicians for specialty services is likely even higher than that suggested by the data on primary care use.

Despite the critical role they play in serving the uninsured, the charity care practices and attitudes of private physicians have not been well established. A recent study by the Center for Studying Health System Change found that the proportion of doctors providing any charity care decreased slightly in recent years, falling from 76.3 percent in 1997 to 71.5 percent in 2001.³ The authors hypothesized that increasing involvement in managed care and resulting reductions in provider payment rates may have constrained physicians' ability to cross-subsidize free care to the uninsured. Data from the AMA's Socioeconomic Monitoring System (SMS) document similar declines in charity care in the late 1990s but found that the proportion of doctors providing charity care in 1999 was actually somewhat higher than it was in the late 1980s.⁴ These findings suggest that factors in addition to the ability to cross-subsidize also influence charity care provision.

Although a majority of physicians provide some charity care, most see relatively few uninsured patients. The SMS data indicate that physicians report 8.8 hours of charity care per week, on average, with about half of this care delivered free of charge and half delivered for a reduced fee. This level of charity care represents approximately 14 percent of total patient care hours.⁵ The Center for Study Health System Change found that, of those physicians providing any charity care, 70.2 percent spend less than 5.0 percent of their total practice time on charity care.⁶ Taken together, these findings suggest that a minority of physicians contribute a relatively high volume of charity care services.

Efforts to quantify physician charity care activities are limited in that they rely on self-reports. These self-reports may be flawed: since charity care is a socially desirable activity, physicians may feel pressure to report providing it. Also, physicians may not be able to accurately identify or recall the

Terminology

- Charity Care — Charges are reduced or eliminated based on patient indigency.
- Bad Debt — Charges are billed, but payments are not received.
- Uncompensated or Pro Bono Care — Includes both charity care and bad debt.

insurance and payment status of their patients. In recognition of the likelihood that physicians' recall of such information will decrease over time, the AMA survey asks about charity care in the most recent week of practice.

It is unclear whether the limitations of self-reports result in under- or overestimations of charity care provision. While social pressures likely serve to inflate reports of charity care provision, the impact of inaccurate identification of charity care patients is more ambiguous. The surveys referenced above define charity care as charging no fee or reduced fee to patients with financial need and instruct physicians to disregard services for which payment was expected but not received. Both the definition and the method for collecting these data are rooted in perceptions and expectations, raising concerns about physicians' ability to accurately distinguish charity care from self-payment and bad debt.

Developing more empirically rigorous estimates of charity care would be a challenging task. Financial accounting principles clearly distinguish between charity allowances (in which charges are reduced or eliminated based on patient indigency) and bad debt (in which charges are made but payment is not received). However, it is uncertain whether the billing systems used in private medical practices would accurately capture the spirit of these distinctions. Unlike hospitals, most physicians do not have formal indigency or charity care policies. Rather, physicians and their office staff make decisions regarding patient billing and collections on a case by case basis, often without a formal assessment of patients' financial status. A routine bill may be issued even if a physician has no expectation that full or partial payment will be forthcoming.

Despite these limitations of existing data, it is useful to examine variations in charity care provision across specialties and geographic regions. These variations likely reflect differences in the underlying need for charity care services, as well as differences in physicians' willingness to provide such services, although these dynamics have not been well studied. Some of the more plausible factors influencing need include (a) varying levels of uninsurance across the country (due in part to differences in state Medicaid programs), (b) differences in the availability of services through subsidized safety net providers such as health centers (which varies both geographically and across types of service), and (c) differences in how well particular types of services, such as mental health, are covered through insurance mechanisms. The factors influencing physicians' willingness to provide charity care services are even less clear but may be linked to regional and speciality-sponsored efforts to encourage volunteerism.

Geographic differences in charity care provision are pronounced (Table 1). Physicians located in metropolitan areas both provide fewer charity care services and are less likely to offer any charity care than physicians in nonmetropolitan areas. Physicians in the south central part of the country offer the most charity care.

Charity care levels also differ significantly across medical specialties (Table 2). A higher proportion of specialists (66.9 percent) than primary care doctors (61.9 percent) provide charity care. In addition, the average specialist provides more hours of charity care per week (9.3) than the average primary care doctor (8.1).

Among specialists, psychiatrists are the most likely to provide charity care, with 73.3 percent delivering some amount. A high proportion of general surgeons also provide charity care, with 73 percent reporting some amount of free or reduced-fee services delivered. However, in terms of time spent providing charity care services, emergency medicine physicians deliver the most charity care, providing an average of 12.3 hours of charity care per week.

In light of the nature of the care provided by emergency medicine physicians and surgeons, these specialists likely have limited discretion in deciding whether to deliver services to uninsured persons. The Emergency Medical Treatment and Labor Act (EMTALA) was intended to ensure timely access to emergency medical care regardless of a patient's insurance status or ability to pay. EMTALA requires hospital emergency departments (EDs) to screen patients presenting there to determine if an emergency medical condition is present, stabilize prior to transfer if an emergency condition exists, or certify that transfer is necessary for medical reasons. Emergency medicine physicians provide the greatest amount of EMTALA-mandated care (22.9 hours per week), followed by general surgeons (5.7 hours per week).⁷

Variations in charity care across specialties may also be related to the efforts of medical speciality organizations. For example, the American College of Surgeons has launched a Giving Back Project aimed at encouraging and recognizing the volunteer efforts of its members.⁸ The project focuses on developing a clearinghouse of information about volunteer opportunities, commending and raising the visibility of individuals who volunteer, studying barriers to volunteerism, and advocating for increased volunteer participation.

The American College of Surgeons distinguishes between pro bono or uncompensated care delivered during the course of practice and volunteerism. The college defines volunteerism as the planned provision

TABLE 1
Physician Provision of Charity Care
by Geographic Location, 1999

	Percent Providing Charity Care	Hours of Charity Care Per Week
All Physicians	64.6	8.8
Metropolitan	63.6	8.7
Nonmetropolitan	71.5	9.3
New England (CT, ME, MA, NH, RI, VT)	67.7	5.8
Middle Atlantic (NJ, NY, PA)	62.5	6.7
East North Central (IL, IN, MI, OH, WI)	60.1	8.4
West North Central (IA, KA, MN, MO, NE, ND, SD)	52.0	7.9
South Atlantic (DE, DC, GA, FL, MD, NC, SC, VA, WV)	70.1	9.2
East South Central (AL, GA, MS, TN)	64.7	15.7
West South Central (AK, LA, OK, TX)	70.8	10.7
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	64.7	9.1
Pacific (AK, CA, HA, OR, WA)	63.8	8.2

Source: Center for Health Policy Research, *Physician Marketplace Report: Physician Provision of Charity Care, 1988-1999*, American Medical Association, April 2002

of services outside the routine practice environment, with no anticipation of reimbursement or economic gain. This distinction recognizes that volunteer efforts represent a tangible commitment not only to the patients being treated but also to professional colleagues and the community at large. However, the extent to which all physicians make this distinction between pro bono care and volunteerism is unclear.

LOCATION, LOCATION, LOCATION

Although data detailing the circumstances surrounding charity care provision are limited, available evidence suggests that the bulk of care is provided in private offices. A recent study focused on general internists found that physicians providing higher volumes of charity care were more likely to provide at least some of that care outside the private office than were low-volume charity care providers.⁹ However, even among the highest-volume charity care providers, only 34 percent of charity care hours were delivered outside the private office.

Charity care is typically delivered in the following settings.

Private Offices

Physicians providing charity care in their private practices may do so informally or through participation in formal referral networks. Referral networks are typically managed by organizations that recruit physicians who commit to accepting a certain number of uninsured patients into their practices and agree to treat these patients at no charge or at greatly reduced fees. The referral networks serve as the conduit for identifying appropriate patients and, so as not to overwhelm any particular provider, generally seek to spread the charity care burden evenly across participating physicians. Some referral networks are quite robust and engage in extensive case management, care coordination, and eligibility screening for public insurance programs.

Although little data are available to document how widespread these referral networks are, available evidence suggests that most charity care is delivered through more informal mechanisms. A recent study of general internists found that most of these physicians' uninsured patients were

TABLE 2
Physician Provision of Charity Care
by Specialty, 1999

	Percent Providing Charity Care	Hours of Charity Care Per Week
All Physicians	64.6	8.8
Primary Care Physicians	61.9	8.1
General/Family Practice	67.3	8.1
General Internal Medicine	60.0	8.1
Pediatrics	61.7	8.4
Obstetrics/Gynecology	56.2	7.9
Specialists	66.9	9.3
Internal Medicine Subspecialties	70.6	8.4
General Surgery	73.0	8.4
Surgical Subspecialties	66.6	8.6
Radiology	68.9	10.6
Psychiatry	73.3	8.1
Anesthesiology	65.3	11.9
Pathology	64.3	7.9
Emergency Medicine	61.2	12.3
Other Specialties	56.2	8.1

Source: Center for Health Policy Research, Physician Marketplace Report: Physician Provision of Charity Care, 1988-1999, American Medical Association, April 2002

established patients who had lost insurance coverage.¹⁰ This same study found that only 35 percent of internists had a policy of charging customary rates to uninsured patients who had difficulty paying full charges and only 27 percent utilized a collection agency if patients failed to pay the anticipated amount.

It is worth noting that, while 80 percent of internists were willing to accept new uninsured patients, only 45 percent were willing to accept new Medicaid patients. The reasons for this difference are not clear, although anecdotal accounts suggest that self-payments by uninsured persons may be greater than the generally low reimbursement offered by state Medicaid programs, even after accounting for reductions in charges and bad debt. Physicians also frequently cite the “hassle factor” associated with Medicaid administrative procedures as a major deterrent to program participation. Participation in organized volunteer activities has been shown to increase physicians’ willingness to open their practices to Medicaid patients.¹¹

Free Clinics

Free clinics are private, nonprofit, community- or faith-based organizations that provide medical, dental, pharmaceutical, mental health, and other services to low-income, uninsured, and under-insured persons for no or very low fee. An estimated 800 to 1,000 clinics are currently operating throughout the country, serving more than 3.5 million uninsured persons annually.¹² (In comparison, federally funded health centers served approximately 4 million uninsured persons in 2001.¹³)

Although each free clinic is unique in how it is organized and operates, most are supported primarily through volunteers and charitable donations. Volunteers include physicians, dentists, nurse practitioners, nurses, pharmacists, and other health professionals and community volunteers. Most clinics limit in some way the types of patients they will serve. Some treat only the working poor; others are limited to persons without any form of insurance coverage, others are focused on a very specific vulnerable population, such as the homeless, members of a certain community, or those with a particular diagnosis.

The services, policies, staffing, and case loads of free clinics vary significantly from clinic to clinic, and national descriptive data are not available to characterize these variations. A recent survey of volunteer-based clinics

American Project Access Network

The American Project Access Network (APAN) assists communities across the nation in developing coordinated systems of charity care based on the Project Access model pioneered in Buncombe County, North Carolina. Initiated by the Buncombe County Medical Society with support from the Robert Wood Johnson Foundation, Project Access provides a full continuum of health care services to uninsured Buncombe County residents with incomes below 200 percent of the federal poverty level.

Project Access relies on physicians who volunteer their time to see patients for free and on other community partners, such as hospitals and laboratories, that donate other medical services patients need. Physician volunteer commitments and patient referrals are managed through a centralized and online database developed for system coordination.

Community-based clinics, in partnership with Medicaid enrollment specialists, conduct outreach, financial assessments, and enrollments. Pharmacies donate counseling and dispensing services, and local governments provide funds to purchase pharmaceuticals. More than 20 communities have adapted the Project Access model to their unique circumstances.

in seven midwestern states found that a majority of clinics have a mixed service area that includes urban, suburban, and rural areas. Free clinics are least common in purely rural settings.¹⁴ The clinics generally operate on small budgets and reported a mean volunteer complement of 22 physicians and 27 nurses. Physician staffing variations are substantial, however, with some clinics exclusively nurse-managed and others staffed by over 100 volunteer physicians. The most commonly offered services are primary care and pharmaceutical assistance. Nearly three-quarters of clinics responding to the survey offer specialty services, over one-half provided dental care, 47 percent provided mental health services, and 38 percent provided immunizations.

Free clinics can be attractive to physician volunteers because these organizations allow physicians to set clear parameters around the level and timing of charity care commitments. Also, the clinic assumes much of the administrative burden associated with patient care, such as maintaining medical records, determining whether patients are appropriate charity care candidates, and scheduling appointments. Although research on free clinics is limited, the evidence suggests that free clinics are most successful when they rely on a funded staff and administrative structure to support the work of volunteers.¹⁵

While the prevalence and reach of free clinics have grown in recent years, very little data is available on the utilization and practices of these care sites. The recently established National Association of Free Clinics is beginning to develop more robust data on the prevalence, nature, experience, and concerns of free clinics across the country.

Hospitals

The amount of charity care delivered in hospitals is not well documented, but the level is likely to be substantial.¹⁶ Hospital-based charity care includes care provided by specialists, such as emergency medicine physicians and surgeons, who practice primarily in hospital settings, as well as services delivered by other physicians who may provide charity care in hospital outpatient departments or through inpatient consultations. It is difficult to determine how physicians employed by hospitals and other facilities report their charity care activities in the surveys referenced earlier in this paper. Although these physicians receive financial compensation through their salaries, their estimates of the time spent providing charity care likely include professional services for which hospitals make charitable allowances.

Other Settings

Although data are lacking, anecdotal evidence suggests that publicly subsidized safety net organizations, such as community health centers, also rely on physician volunteerism. While some physicians provide their services at health centers, it is more common for physicians to agree to see uninsured patients on a pro bono basis for specialty referrals in their

own offices. Clinics that focus on special populations, such as the homeless, are perhaps the most likely to host volunteer physicians on-site. Opinions are mixed on the extent to which existing regulatory and oversight policies restrict the participation of volunteers in health centers, public hospitals, and other traditional safety net sites. Some believe that the stringent policies governing these facilities are critical to maintaining high quality care and accommodating volunteers may not be feasible. Others feel that traditional safety net providers could be more proactive in soliciting volunteer participation.

BARRIERS TO VOLUNTEERISM

Physicians choose to volunteer their time and medical expertise for a variety of reasons.¹⁷ Many physicians have pursued careers in medicine because they are committed to helping others and see volunteer activities as contributing to this goal. Some physicians recognize that routine health care can avert serious medical problems and volunteer in order to prevent an escalation of health care needs in their communities. In some cases, physicians volunteer because they are asked to do so by colleagues or mentors. Others physicians—such as those who are retired, teach or conduct research full-time, or are not actively treating patients—volunteer to maintain clinical skills that might otherwise not be used.

Just as there are many factors motivating physicians to volunteer, numerous obstacles may hinder or limit their willingness to provide charity care. These barriers represent real obstacles; however, some may be rooted in misguided physician attitudes and beliefs. Volunteers in Health Care, a national resource center funded by the Robert Wood Johnson Foundation to help organizations develop or expand volunteer-based health care programs for the uninsured, has identified a number of these concerns.¹⁸

Misunderstanding of Needs

Physicians may not be fully aware of the need for charity care, either for individual patients or for the community at large. While physician offices clearly track and record their patients' insurance status, administrative staff may be uncomfortable asking uninsured patients about their income levels and ability to pay for services. In some cases physicians may provide "charity care" only in the sense that they do not pursue aggressive collection techniques with self-pay patients who fail to pay their bills and then "write off" these unpaid services as bad debt. Similarly, physicians may not be aware of the level of uninsurance in their communities (particularly in affluent communities with less visible pockets of underservice). Many physicians are not familiar with the categorical nature of Medicaid eligibility and mistakenly believe that Medicaid covers all low-income persons. Alternatively, physicians may recognize the level of community needs regarding the uninsured but may believe that these needs are adequately addressed by other service providers.

Many physicians mistakenly believe that Medicaid covers all low-income persons.

Constraints on Time Commitments

Private practice physicians may be reticent to publicize their willingness to provide charity care because they are concerned about being overwhelmed by uninsured patients. A high volume of uninsured patients could undermine the financial viability of their practices. For physicians considering participation in free clinics or other volunteer service, these concerns may center on limitations in the amount of personal time available for volunteering, particularly in light of “on call” responsibilities and other professional obligations outside of patient care.

Personal Safety

Potential threats to safety may dampen physicians’ willingness to volunteer, particularly among those considering volunteer activities at clinics that may be located in high crime areas. Perceptions regarding high rates of communicable disease and substance abuse may also dampen physicians’ willingness to treat the poor.

Availability of Pharmaceuticals, Referrals, and Ancillary Services

Physicians can be reluctant to provide services to the uninsured because they worry that the resources necessary to complement their professional services, such as pharmaceuticals, diagnostic testing, and specialty referrals may not be available. A recent survey of internists found that, while 92 percent of physicians believed they could provide acceptable quality of care to insured patients, only 74 percent believed they could offer the same level of care to uninsured patients.¹⁹ Approximately one-third of responding physicians believed they could maintain continuity of care for the uninsured, only 9 percent believed they could be assured of securing laboratory tests, and only 5 percent thought they could be assured of obtaining diagnostic tests for uninsured patients. Less than one-fourth of internists reported that they could provide medications to their uninsured patients or refer them to specialists “most of the time or often.” Many physicians become frustrated by their inability to ensure quality of care under these circumstances and, instead, seek to avoid these situations. Uninformed perceptions about working conditions at indigent care clinics may further dissuade physicians from volunteering. They may have concerns that these clinics are subpar, with poorly functioning equipment, limited supplies, and disorganized records management.

Beliefs regarding Uninsured Patients

Physicians may view uninsured patients as undesirable for reasons beyond financial risk, such as a belief that patients referred through an indigent care program will be unreliable in keeping their appointments. Such “no shows” and the resulting rescheduling required disrupt office operations.

Physicians worry that the resources necessary to complement their professional services, such as pharmaceuticals and diagnostic testing, may not be available.

Physicians may also be concerned that indigent patients will not be compliant with medical guidance. Some physicians may be reluctant to provide charity care through their private practices because they believe their established patients might be put off by the behavior or appearance of indigent patients.

Legal Concerns

Potential volunteers are likely to have concerns about medical malpractice insurance and liability exposure. These concerns stem, in part, from inaccurate perceptions that the poor are more litigious than other patients,²⁰ but also from limitations in malpractice liability coverage. In some cases a clinician's malpractice coverage may not apply to volunteer activities. For example, the malpractice coverage for clinicians employed by an institution, such as a hospital or medical center, may be limited to patients seen in the scope of employment and would not apply to care delivered at free clinics or other sites.

Although the malpractice insurance coverage of private practice physicians generally covers them regardless of where they are practicing, their coverage may be limited to a certain scope of practice, or they may be wary of the liability exposure generated by care to the poor. Also, some malpractice insurance carriers base their rates on the volume of services a physician or physician group renders. Increases in volume stemming from additional volunteer services would raise insurance rates for physicians covered under this type of policy. Retired physicians and other clinicians who do not maintain their own malpractice coverage face special challenges. In addition to the malpractice insurance costs, these physicians must also consider the costs of licensure and continuing education. In light of these liability concerns, many organized volunteer programs, both clinics and referral networks, have secured malpractice insurance for their volunteers. Malpractice insurance costs in general have increased substantially in recent years, although considerable variation exists across states and medical specialties.²¹

POLICY EFFORTS TO ENCOURAGE VOLUNTEERISM

The major thrust of public policy supporting physician volunteerism has focused on easing malpractice liability concerns. Most states have enacted laws that provide some protections from malpractice liability for volunteer clinicians.²² In some states these protections extend beyond physicians to include other categories of health care workers, such as dentists and nurse practitioners. These protections are generally distinct from measures covering emergency situations (typically called "Good Samaritan" laws) which have been enacted to encourage people, particularly trained health professionals, to provide emergency assistance to injured persons. (Emerging concerns related to emergency preparedness have raised numerous issues related to the adequacy of these laws in the event

Retired physicians who do not maintain their own malpractice coverage face special challenges.

of mass casualty incidents. Although critically important, the following analysis does not address these emergency situations and focuses on malpractice liability related to charity care delivered to the poor.)

State Approaches to Charitable Immunity

State laws addressing the nonemergent volunteer context, also known as charitable immunity legislation, generally follow one of two strategies: changing the negligence standard or indemnifying the volunteer provider.²³

Changing the Negligence Standard — The most common approach to malpractice liability protection is changing the standard of care to which the volunteer is obligated. Under this approach the standard for demonstrating malpractice is raised from proving simple negligence to proving gross negligence, which is generally much more difficult for plaintiffs to establish. This more demanding standard often requires an injured person to prove that the volunteer had a conscious indifference to the consequences of his or her actions.

Indemnifying the Volunteer Provider — At least ten states extend the liability protections enjoyed by governmental employees through governmental/sovereign immunity to volunteer clinicians.²⁴ Legislation of this type often caps the compensatory damages that can be awarded to injured persons and exempts the state from punitive damages. Most states that indemnify volunteer clinicians in this way also change the negligence standard of care.

In enacting these laws, states have generally established restrictions or limitations on their use. These provisions may specify the setting (such as free clinics or community health centers) in which volunteer care must be delivered to qualify for the protections, restrict the range of medical services protected (such as limiting services to primary care), or require patient notification of the liability limitations.

Each state has pursued its own unique approach to charitable immunity legislation. Some have also established mechanisms and funding for purchasing malpractice insurance for volunteer clinicians. While these approaches offer substantial liability protections to volunteer physicians, they do not offer complete protection. The state laws do not prevent patients from filing lawsuits, which may influence malpractice insurance rates, regardless of case outcomes, and they may not cover the legal expenses volunteers may incur in defending against suits.

Malpractice Coverage and the Federal Tort Claims Act

Federal policymakers have also acted to ensure that liability concerns do not hamper physician volunteerism.²⁵ In 1996, under Section 194 of the Health Insurance Portability and Accountability Act, Congress amended the Public Health Service Act to deem certain qualified clinical volunteers working at free clinics “employees” of the U.S. Public Health Service. As

such, they are personally protected by the federal government from malpractice liability through the Federal Tort Claims Act (FTCA). In a manner similar to many state laws, Section 224(o) of the Public Health Service Act indemnifies clinical volunteers under delineated circumstances.

In its appropriations for fiscal year (FY) 2004, Congress included \$4.8 million to fund this extension of FTCA coverage to volunteers in free clinics. It is important to note that this policy does not extend FTCA coverage to employees of free clinics, such as the nurse managers who coordinate services or administrative personnel, so most clinics must still carry some amount of malpractice coverage. Furthermore, some clinics collect nominal payment from patients, typically on a sliding scale, and others serve Medicaid patients (in response to low provider participation rates in some areas) and seek reimbursement from Medicaid programs. These clinics may not be eligible to participate in the FTCA coverage.

The future impact of this federal policy change is difficult to predict. The Public Health Service Act has extended similar malpractice liability protections to employees of federally funded community health centers since 1992. These provisions are limited, however, to clinicians employed by health centers; they do not extend to physicians who volunteer their time at these facilities. Despite some important differences, the experience of health centers under FTCA provides a useful template for considering how FTCA coverage could be implemented for free clinic volunteers.

Health centers must submit an application to the Health Resources and Services Administration (HRSA) to be designated a “deemed” organization to be eligible for FTCA coverage. The deeming application is fairly detailed and must demonstrate that the health center has implemented specific risk management practices and has reviewed and verified the credentials of its providers. Health centers’ adherence to these stipulated practices is reviewed through auditing and other oversight procedures used to monitor health center compliance with federal regulations. Although some clinicians practicing in health centers may carry independent malpractice coverage, patients wishing to file malpractice claims against health center providers must use the FTCA mechanism as their sole legal remedy.

Tort claim funds are deposited into and drawn from HRSA’s Health Center Judgment Fund. As of the end of FY 2003, 1,279 claims had been filed against this fund and 224 of these claims had been paid. Total claims obligations under the program from its inception in 1993 to the end of FY 2003 were approximately \$79 million, while total appropriated deposits were \$95.7 million. Information is not available on how many of the open claims could lead to suits or additional payments.

Claims and payment obligations have risen significantly since the fund’s inception and have raised concerns over the long-term burden and funding requirements of the program. However, although federal outlays have grown significantly, FTCA has proven to be a cost-effective mechanism for

FTCA malpractice coverage has proven to be cost-effective for health clinics.

providing malpractice coverage to health centers. If FTCA coverage were not in place, health centers would have spent an estimated \$1.05 billion on malpractice insurance premiums from 1993 to 2003.²⁶

The applicability of the health centers' liability experience to free clinics is unclear. Free clinics serve a different patient population and generally offer a less comprehensive range of services than health centers. For example, obstetrical and pediatric care are rarely provided by free clinics, and high malpractice claim volume and award amounts are often linked to these services. A recent informal survey conducted by the National Association of Free Clinics found an extremely low volume of malpractice claims against free clinics. For the clinics responding, only seven suits had been filed and, of these, three were later dropped. A similar survey conducted by Volunteers in Health Care identified only 8 suits among the 104 free clinics responding.

While the historic malpractice experience of free clinics appears to be low, the credentialing and risk management activities of these clinics are not uniform, nor are they subject to federal oversight. This lack of consistent standards has raised concerns regarding HRSA's ability to exercise appropriate stewardship over the extension of FTCA coverage to free clinics. The authorizing legislation requires that free clinics adhere to the same deeming requirements imposed on health centers. This is a fairly high bar for free clinics to meet, particularly since many do not currently engage in rigorous independent credentialing procedures. Therefore, it is unclear how many clinics will seek deemed status for FTCA coverage. The level of existing state-based malpractice protections, the degree to which individual clinics rely on retired physicians and others not carrying their own coverage, and the cost of malpractice insurance will likely determine how many clinics choose to participate.

Additional Policies to Support Volunteerism

Although laws aimed at reducing malpractice risks are the most visible policy vehicle for supporting physician volunteers, other policy tools have been pursued or are being advocated. With uninsurance rates growing, policymakers are increasingly exploring ways that public support can better leverage physicians' charity care efforts. These policy efforts seek to preserve and encourage the fundamental concept of physicians volunteering their time and professional expertise but strive to provide the ancillary medical services and administrative support necessary for those efforts to be effective, efficient, and appealing to volunteers.

Private philanthropy is the largest source of support for physician volunteer activities; however, local, state, and federal government dollars have also been used to fund free clinics and organized physician referral networks. The equipment, supply, and administrative needs of these endeavors are significant, particularly for those organizations that focus on ensuring continuity of care through proactive case management

Free clinics' malpractice experience is low, but their credentialing and risk management activities are neither uniform nor subject to federal oversight.

and state-of-the-art information systems. Although both federal and state governments have earmarked grant funds for particular free clinics, few systematic subsidies for volunteer activities exist.

The Healthy Community Access Program (HCAP), administered by HRSA since the program's inception in 2000, represents the most prominent form of direct federal subsidies to support volunteerism by health care professionals. HCAP grants help communities and health care providers coordinate safety net services for uninsured and underinsured persons. Communities have established a variety of coordination mechanisms using HCAP funds, ranging from the development of information systems to promote seamless transitions for uninsured patients to the creation of disease management programs targeting the uninsured.

Although not explicitly focused on promoting volunteer activities, a large number of HCAP grantees incorporate physician volunteers in their efforts. Nearly 80 percent of HCAP grantees have established some type of referral network to help uninsured patients access primary, specialty, dental, mental health, substance abuse, or social services.²⁷ Providers participating in these referral networks, it may be assumed, recognize that referred patients have limited ability to pay for required services and accept the associated charity care burden. However, only 16 percent of HCAP grantees report that grant funds directly facilitate the provision of care by volunteer doctors. HRSA has not collected data on the number of grantees that have established free clinics using HCAP funds. HCAP received a FY 2004 appropriation of approximately \$104 million and was authorized for FY 2002–2006 by the Health Care Safety Net Amendments Act of 2002.

Additional policy proposals have focused on making pharmaceuticals, supplies, and other ancillary service supports more affordable for volunteer physicians. Because physician willingness to volunteer time is linked to their ability to provide comprehensive, high-quality care, policies that minimize these barriers have the potential to significantly increase volunteerism. For example, expansion of the 340 B Drug Pricing Program, which limits the costs of drugs for federal purchasers and certain grantees of federal agencies, to include free clinics could make pharmaceuticals more affordable to uninsured patients and might indirectly encourage increased physician participation. Free clinics in several states are seeking legislation to treat them as governmental entities for the purpose of purchasing pharmaceuticals through the Minnesota Multi-State Contracting Alliance for Pharmacy. Similarly, policy changes to the Prescription Drug Marketing Act, which addresses the distribution of pharmaceutical products by drug manufacturers through wholesale and retail channels, are being sought to reduce obstacles for free clinics and other charitable providers who rely substantially on manufacturer samples and donations to meet their patients' prescription drug needs.

States are beginning to consider more formal ways to tie volunteer efforts to Medicaid and other state-sponsored programs. For example, Utah has

Nearly 80 percent of HCAP grantees have established referral networks for uninsured patients.

created a Primary Care Network through a Section 1115 Medicaid waiver which expands Medicaid eligibility for low-income adults but limits benefits to primary care and preventive services. Inpatient and specialty care are not covered through Medicaid for these newly eligible enrollees, but the state has worked with hospitals and physician groups to arrange for charity care referrals.²⁸ It remains unclear whether this partnership will be adequate for meeting beneficiary needs in the long run. Eventually, some beneficiaries may need to secure specialty and inpatient services on their own if the referral network becomes overwhelmed.

A few states have sought to create a monetary incentive for charity care by creating tax credits for physicians who volunteer their services to the indigent. For example, Virginia's Neighborhood Assistance Program provides tax credits to physicians who donate time at designated free clinics.²⁹ These tax credits can be applied against participating physicians' state income tax liability. Tax credit amounts are equal to 45 percent of the value of professional services rendered (capped at \$125 per hour). Designated clinics receive tax credit allocations, administer necessary paperwork, and issue tax credit certificates to participating providers, who can include these certificates in their income tax filings.

As uninsurance rates grow, policymakers will likely explore additional measures to assist and augment physician volunteerism through both public funding and supportive policies. Many see these steps as a cost-effective way to expand access to care. By layering public support on a foundation of private philanthropy, some policymakers hope to bolster existing community-based assets to address the needs of the uninsured. Others, however, see these proposals as stopgap measures that distract from more comprehensive and sustainable access improvements, such as expanding insurance coverage and institutionalizing safety net resources.

CONCLUSION

As policymakers implement existing policies to encourage volunteerism and consider additional proposals, they will face questions related to the priority of these measures relative to other access improvements. But they will also confront other, more ambiguous questions regarding the impact of increased government involvement in what has historically been a purely philanthropic response to care for the medically indigent. In many cases, physicians have pursued volunteer activities as a purposeful non-governmental alternative that allows them to honor their professional obligation to care for the poor, while avoiding what they perceive as bureaucratic interference in patient care. The extent to which expanded public policy in this area either increases or undermines volunteerism will no doubt depend on specifically which policies are adopted and, perhaps more importantly, how they are implemented.

In light of the continuing debate regarding their merit and impact, federal and state policies to support and encourage volunteerism by health

Utah's 1115 Medicaid waiver limits specialty and inpatient care for new enrollees but establishes linkages with volunteer networks for these services.

care professionals warrant considered attention and evaluation. Recent policy changes have already significantly increased the federal role in extending malpractice coverage to physician volunteers in free clinics and raise new and complex oversight challenges. The implementation of these malpractice protections will require a careful balancing act. Safeguards must be established to protect federal assets. Yet at the same time, heightened regulation of volunteer activities could unintentionally undermine the very efforts the new policy is designed to support.

ENDNOTES

1. Karen Geraghty, "The Obligation to Provide Charity Care," *Virtual Mentor*, American Medical Association, October 2001; accessed November 13, 2003, at <http://www.ama-assn.org/ama/pub/category/6567.html>.
2. Christopher B. Forrest and Ellen-Marie 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 (October 25, 2000): 2077–2083.
3. Peter J. Cunningham, "Mounting Pressures: Physicians Serving Medicaid Patients and the Uninsured, 1997-2001," Tracking Report No. 6, Center for Studying Health System Change, December 2002; accessed November 11, at <http://www.hschange.com/content/505/>.
4. Carol K. Kane, "Physician Provision of Charity Care, 1988-1999," Physician Marketplace Report, American Medical Association, April 2002, 7.
5. Kane, "Physician Provision," 7.
6. Cunningham, "Mounting Pressures."
7. Carol K Kane, "The Impact of EMTALA on Physician Practices," Physician Marketplace Report, American Medical Association, February 2003.
8. Andrew L. Warshaw, "The American College of Surgeons Volunteerism and Giving Back to Society among Surgeons Project: Phase Three—Survey of ACS Fellows," American College of Surgeons, September 2002; accessed March 1, 2004, at <http://www.facs.org/about/governors/phase3givingback.pdf>
9. Gerry Fairbrother, Michael K. Gusmano, Heidi L. Park, and Roberta Scheinmann, "Care for the Uninsured in General Internists' Private Offices," Market Watch, *Health Affairs*, 22, no. 6 (November/December, 2003): 221.
10. Fairbrother et al., "Care," 219.
11. H. Denman Scott, Johanna Bell, Stephanie Geller, and Melinda Thomas, "Physicians Helping the Underserved: The Reach Out Program," *Journal of the American Medical Association*, 283, no. 1 (January 5, 2000): 99–104.
12. Stephanie Geller, Buck M. Taylor, and H. Denman Scott, "Free Clinics Helping to Patch the Safety Net," *Journal of Health Care for the Poor and Underserved*, 15, no. 1 (February 2004). See also National Association of Free Clinics Web site at <http://www.nafclinics.org>.
13. Health Resources and Services Administration, "Bureau of Primary Care" *HRSA Annual Report FY 2002*, U.S. Department of Health and Human Services, Rockville, MD (no date); accessed March 1, 2004, at <http://www.hrsa.gov/annualreport/part4.htm>.
14. Geller, Taylor, and Scott, "Free Clinics."
15. Scott et al., "Physicians Helping."
16. Fairbrother et al., "Care," 221.

17. Gayle Goldin and Sarah Hanson, "Recruiting and Retaining Medical Volunteers: A Volunteers in Health Care Guide," *Volunteers in Health Care*, Pawtucket, RI, 2002, 4; accessed December 13, 2003, at <http://www.volunteersinhealthcare.org/Manuals/MD.Recrut.manual.pdf>.
18. Goldin and Hanson, "Recruiting," 5–13.
19. Fairbrother et al., "Care," 221–222.
20. H. R. Burstin, W. G. Johnson, S. R. Lipsiz, and T. A. Brennan, "Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socioeconomic Status," *Journal of the American Medical Association*, 270, no. 14 (October 13, 1993): 1697–1701.
21. U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increases in Premium Rates*, GAO-03-702, Washington, DC, June 2003; accessed March 3, 2004, at <http://www.gao.gov/new.items/d03702.pdf>.
22. Paul A. Hattis and Sonya Staton, "Understanding Charitable Immunity Legislation: A Volunteers in Health Care Guide," *Volunteers in Health Care*, Pawtucket, RI, 2002, 6; accessed date, at <http://www.volunteersinhealthcare.org/Manuals/Charit.Imm.Man.pdf>.
23. Hattis and Staton, "Understanding," 9–12.
24. As of 2002, the following states extended these liability protections: Florida, Iowa, Kansas, Louisiana, Missouri, Nevada, Oregon, Tennessee, Virginia, and Wisconsin. Hattis and Staton, "Understanding."
25. The Volunteer Protection Act, passed by Congress in 1997, although not focused specifically on clinical volunteers, provides all volunteers of nonprofit and government entities with limited protection from liability for certain harms caused by acts of omissions related to their volunteer duties.
26. Triton Group, unpublished study completed by DS Actuarial Associates, undated.
27. Health Resources and Services Administration staff, personal communication with author, February 10, 2004.
28. State Coverage Initiatives, "Profiles in Courage: Utah's Primary Care Network," Robert Wood Johnson Foundation, November 2003; accessed March 4, 2004, at <http://www.statecoverage.net/utahprofile.htm>.
29. Virginia Department of Social Services, "Neighborhood Assistance Program" Web site; accessed February 24, 2004, at <http://www.dss.state.va.us/business/nap.html>.