

Caring for the Uninsured: A Physician's View from the Safety Net

C. Annette DuBard, MD, MPH

Making do without health insurance is an experience familiar to an increasing number of Americans. By now, 13% of non-elderly adults have had at least one gap in coverage during any two-year period. Included among them are a disproportionate number of racial and ethnic minorities and an alarming proportion of the poor. Lack of health insurance typically does not reflect a lack of need for healthcare. On the contrary, the uninsured consistently have worse clinical outcomes and suffer greater risk of premature death than the insured.¹ The uninsured share something else in common—a front-row view of the worst our healthcare system has to offer: maldistribution of primary and preventive care availability, fragmentation of services and lack of communication between providers, and the exorbitant price inflation that results from layers of overhead costs and complex payer arrangements.

Inside the Safety Net

I work in the so-called safety net, as a family physician in a federally-supported community health center, where virtually all patients live below 200% of the federal poverty level, and 40% are uninsured. Community health centers pride themselves on providing affordable, comprehensive, patient-centered primary care regardless of a patient's ability to pay. By multiple measures, such clinics provide a quality of care that equals or exceeds that of other healthcare providers, alleviates the health disparities that are plaguing our nation, and reduces overall healthcare costs by decreasing preventable hospitalizations and emergency department use.²⁻⁸ We are only one small piece of the safety net puzzle, which includes health departments and free clinics, hospitals and outpatient teaching clinics, and the countless private practice physicians who absorb much of the cost of caring for the uninsured.

It is a joy to provide a true medical home for patients who are so accustomed to being shuffled around and receiving band-aid solutions for immediate, acute healthcare needs, with no plan for follow-up care beyond “anywhere but here.” Uninsured patients who find their way into a stable source of ongoing, affordable, comprehensive primary care must learn a whole new way of interacting with the healthcare system. It becomes possible for them to think beyond immediate concerns, toward long-term approaches to maintaining good health and responsibly managing chronic disease. My vantage point debunks the negative mythology that surrounds the uninsured. I don't feel like anyone is looking for an opportunity to sue me,

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or wanting “something for nothing.” I don't feel a lack of “gratitude.” Typically, the more I understand of my patients' lives, the more I respect what they're up against. Nationally, more than 8 in 10 uninsured come from working families. My billing office, which discounts charges based on the patient's income, reports that 90% of our patients pay 100% of what is asked of them.

C. Annette DuBard, MD, MPH, is a family physician with Piedmont Health Services, Inc. in Burlington, NC. She will complete a preventive medicine residency at the University of North Carolina School of Medicine in June. She can be reached at annettedubard@hotmail.com or CB# 7240, Chapel Hill, NC 27599-7240. Telephone: 919-643-1674.

The Skill Set of Safety Net Providers

The core competencies of my job—what I know of the social, behavioral, and environmental determinants of health, the workings of social services, and the politics of healthcare—I've learned on the job, patient by patient. Taking care of the indigent uninsured requires a skill set that is not measured by any degree, board certification, or compensation system. It requires communication in a language that the patient can understand—for almost half of my patients, that means Spanish. For so many others, it's English at a fifth grade level. It requires a willingness to accommodate to the demands of my patients' lives—their complicated work schedules, frequent changes of address and intermittent phone service, the unpredictable availability of transportation or childcare from a friend or family member—which means working in one more patient at the end of today who didn't show up yesterday and taking on far more than just the "chief complaint" at any visit. It requires agility in phar-maco-economics at the micro level: emptying the grocery sack full of assorted pill bottles and samples or scrutinizing the stack of unfilled prescriptions from the last hospital discharge and starting over based on the amount of cash in the patient's pocket. Which can be substituted with a cheaper alternative? Could we get this one from a patient assistance program? What must be filled today; what can wait until the next paycheck; and what can we do without?

We learn, in the primary care safety net, an alternative way of doing medicine: what you can with what you've got. Expertise in our field requires knowledge of at least two approaches to any diagnostic or therapeutic problem. If you come to me with worsening asthma, or severe headaches, or abnormal liver tests, or infertility, I will flip straight to the section of your chart that tells me whether you have insurance. I will provide you the best care I can, but it will be tailored to your situation—which medications you can afford to try, which tests you can afford to undergo, how likely a specialist is to see you in consultation. I shoulder the knowledge that if my patient has a need that I can't take care of, that need will likely go unmet. So I've learned how to apply dental varnish for children who can't see a dentist. I do office procedures for which insured patients would be referred elsewhere. I work into my rushed visits tidbits of dietary guidance for diabetics who have no access to a dietician and brief counseling for patients suffering mental illness who have no access to a mental health professional. It is not enough.

When the Safety Net Falls Short

When patients' needs extend beyond primary care, my role is to help them navigate the healthcare system outside my doors, which is a challenge for anyone, but a particularly daunting task for those with no buying power (even if, like my

patients, they live within 45 minutes of four hospitals, in a region of the state with one of the highest concentrations of specialist physicians). The tertiary medical center will say, "that sounds like something that can be handled at the local hospital," and the local hospital will say, "that sounds more appropriate for the tertiary medical center." For less urgent requests for consultation, any number of barriers may fly up. Patients may be asked to pay in full up front, to arrange an appointment with a financial counselor before a medical appointment can be made, to bring their own interpreter if Spanish-speaking, to send in written information or prior medical records for review and await a phone call if the referral is deemed appropriate. Important and substantial exceptions to this can be identified in every community, but institutional barriers to getting patients to the care they need grow in direct correlation with growth in the number of uninsured and under-insured. Too often, that means patients leave my office with the disgraceful advice: "you'll just have to go to the emergency room the next time it happens (the chest pain, the gallbladder attack, the seizure, the severe headache)."

It's Time for Real Solutions

All this is to say that strengthening the primary care safety net is a good and critical thing, but it will never be a substitute for universal health coverage. Despite federal initiatives that have emphasized expansion of safety net capacity in recent years, healthcare providers serving the uninsured are feeling increasingly strained. The 1.3% increase in total federal spending for care for the uninsured from 2001-2004 pales in comparison to the 11.2% increase in the number of uninsured over this time period.⁹ More than 40% of the uninsured have no regular source of care, and 20% consider the emergency room to be their regular source of care. Almost half have had to postpone seeking care because of cost within the past year.¹⁰

Is it not shameful that in this, the richest nation on earth, 45.5 million people cannot count on access to basic healthcare services? Are we to be proud of our achievements in building the "best medical care in the world" while rationing that care in the most vicious of ways: all for some and none for so many? When I go to work tomorrow, I can expect to see someone whose colon cancer wasn't diagnosed until too late because screening was not available to her. I will see someone who has been disabled by a stroke because he never received adequate care for his high blood pressure and diabetes. I will see someone who keeps missing work or school because of asthma attacks, but cannot afford the medicine that would prevent them. What my patients need is not a safety net, but a healthcare system that makes sense. **NCMedJ**

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REFERENCES

- 1 Institute of Medicine. Uninsurance facts and figures: The uninsured are sicker and die sooner. The Institute of Medicine of the National Academies. Washington, DC. Available at: www.iom.edu/uninsured. Accessed May 1, 2006.
- 2 Carlson BL, Eden J, O'Connor D, Regan J. Primary care of patients without insurance by community health centers. *J Ambul Care Manage* 2001;24(2):47-59.
- 3 Epstein AJ. The role of public clinics in preventable hospitalizations among vulnerable populations. *Health Serv Res* 2001;36(2):405-420.
- 4 Hadley J, Cunningham P. Availability of safety net providers and access to care of uninsured persons. *Health Serv Res* 2004;39(5):1527-1546.
- 5 Politzer RM, Yoon J, Shi L, Hughes RG, Regan J, Gaston MH. Inequality in America: The contribution of health centers in reducing and eliminating disparities in access to care. *Med Care Res Rev* 2001;58(2):234-248.
- 6 Proser M. Deserving the spotlight: Health centers provide high-quality and cost-effective care. *J Ambul Care Manage* 2005;28(4):321-330.
- 7 Shin P JK, Rosenbaum S. Reducing Racial and Ethnic Health Disparities: Estimating the Impact of High Health Center Penetration in Low-Income Communities. Prepared for the National Association of Community Health Centers, September 2003. Available at: www.gwhealthpolicy.org/downloads/GWU_Disparities_Report.pdf. Accessed May 1, 2006.
- 8 Starfield B, Shi L. The medical home, access to care, and insurance: A review of evidence. *Pediatrics* 2004;113(5 Suppl):1493-1498.
- 9 Kaiser Family Foundation. Growth in Uninsured Americans Outpacing Federal Spending on the Health Care Safety Net. Kaiser Commission on Medicaid and the Uninsured. Menlo Park, CA. Available at: <http://www.kff.org/uninsured>. Accessed May 1, 2006.
- 10 Kaiser Family Foundation. The Uninsured: A Primer. Key facts about Americans without health insurance. Kaiser Commission on Medicaid and the Uninsured. Menlo Park, CA: January 2006. Available at: <http://www.kff.org/uninsured/upload/7451.pdf>. Accessed May 1, 2006.

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