HEALTH CARE REFORM

Free Clinics in the United States

A Nationwide Survey

Julie S. Darnell, PhD, MHSA

Background: Since an increasing proportion of the US population is without health insurance, a network of free clinics has gradually developed to provide care for the uninsured. Despite widespread concern about the uninsured and the viability of the safety net, free clinics have been overlooked and poorly studied, leaving old assumptions and beliefs largely unchallenged. As a result, policy discussions have been forestalled and potentially fruitful collaborations between free clinics and other safety net providers have been hindered. The objective of this study is to describe the attributes of free clinics and measure their contribution to the safety net.

Methods: National mail survey of all known free clinics in the United States. The main outcome measures were organizational structures, operations, revenue sources, patient profiles, services, and staffing.

Results: The study represents the first census of free clinics in 40 years and garnered a 75.9% response rate. Overall, 1007 free clinics operated in 49 states and the District of Columbia. Annually, these clinics provided care for 1.8 million individuals, accounting for 3.5 million medical and dental visits. The mean operating budget was $287 810. Overall, 58.7% received no government revenue. Clinics were open a mean of 18 hours per week and generally provided chronic disease management (73.2%), physical examinations (81.4%), urgent/acute care (62.3%), and medications (86.5%).

Conclusions: Free clinics operate largely outside of the safety net system. However, they have become an established and meaningful contributor to it. Policymakers should consider integrating the free clinic network with other safety net providers or providing direct financial support.

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OUR NATION'S 46 MILLION uninsured[1] often delay or forego needed health care because the cost is prohibitive.[2-6] Traditional sources of primary care include private physicians, federally qualified health centers (FQHCs), public clinics, hospital outpatient departments, and emergency departments. More important, most require cost-sharing. The mean cost to an uninsured patient for a physician visit—the usual source of care for one-third of the uninsured[7]—has been reported to be more than $50.[8-10] The FQHCs are required to use a fee scale based on a patient's annual income and family size: fees range from $5 to $24 for patients whose income is at the poverty level to $87 for patients whose income is twice that level.[11,12] Moreover, FQHCs bill patients. Public clinics also collect fees,[13] ranging from $22 for patients whose income is at the poverty level to $97 at twice the poverty threshold.[11] Aside from cost considerations, care is frequently difficult to find, especially for those with the least resources.[8]

On the margins of the formal health care safety net for uninsured people, free clinics serve to partly offset these costs and access problems. Structured as private, nonprofit organizations, free clinics offer basic health care services to uninsured patients by licensed volunteer clinicians at little or no cost. Very little is known about free clinics despite their being one of the few viable options for uninsured people with limited funds.

See Invited Commentary at end of article

Free clinics have evolved from ad hoc "outlaw force[s] in medicine,"[14(p156)] treating drug addicts and runaway youth,[15-18] and shunned by the American Medical Association,[14] to an established component of the health system.[19-22] The American Medical Association began to support free clinics in 1994.[23] Also in the 1990s, a $12 million Robert Wood Johnson Foundation initiative supported their development.[24] Finally, through the Health Insurance Portability and Accountability Act of 1996, the US Congress

Author Affiliations: School of Social Service Administration, The University of Chicago, Chicago, Illinois. Dr Darnell is now with the Division of Health Policy and Administration, School of Public Health, University of Illinois at Chicago.

has extended medical malpractice protection for volunteer free clinic health care professionals.

The free clinic literature is dominated by accounts of individual clinics rather than the sector as a whole. These accounts cover free clinics' birth and development,[25-32] programs and services,[33-35] patients,[18,36-43] staff or volunteers,[44-47] and care quality.[19,35,48,49] A few studies describe the free clinic movement,[50-52] free clinics in general,[53] volunteerism,[24,54-56] medical student–run clinics,[29,57-62] and free clinics in one state,[27,63,64] region,[22] or nation.[65-68] The last census (59 clinics) was conducted in 1967-1969.[66]

Three national studies[54,65,67] and 1 regional study[22] are the only attempts in recent decades to characterize the free clinic sector. Each study, however, has substantial limitations. None applies standard criteria to define free clinics, which means that these studies likely describe a mixture of free clinics, low-cost charitable clinics, and federally supported clinics. In addition, all the studies have limited reach; 2 studies[54,65] use outdated sources and 1 study[54] combines 2 distinct models: free clinics and "free clinics without walls" in which physicians (usually specialists) provide free care in their offices. To address these limitations, I conducted a national survey of all known free clinics in which I examined their structures and operations, funding sources, caseload, staffing, and range of services. I sought to evaluate the extent to which these providers are functioning as a meaningful component of the safety net system.

METHODS

STUDY POPULATION

Data sources included member lists from all national, regional, and state free clinic associations; a mailing list from Volunteers in Health Care (a now-defunct organization that supported free clinics); publicly available directories; Guidestar (http://www2.guidestar.org/), a database of more than 1.5 million Internal Revenue Service–recognized nonprofits; the Medical Student–Run Clinics of America; state primary care associations, area health education centers, and medical schools; the Internet; and survey respondents, who were asked to list free clinics in their communities. This latter snowball sampling technique generated both previously identified and previously unidentified free clinics. Altogether, these disparate sources yielded a list of 2545 potential free clinics.

An organization was operationally defined as a "free clinic" if it met all the following criteria: being a private, nonprofit organization or program component of a nonprofit; providing medical, dental, or mental health services and/or medications directly to patients; serving mostly (>50%) uninsured patients; charging no fees or nominal fees of not more than $20; not billing patients, denying services, or rescheduling appointments if the patient could not pay the requested fee/donation; and not being recognized as a FQHC or Title X family planning clinic. Clinics that received reimbursement from any third party and clinics that used salaried staff were included if the other criteria were met. Clinics that provided only pregnancy testing and/or counseling services, sexually transmitted disease testing, or human immunodeficiency virus testing were excluded. By excluding clinics supported directly by federal programs, setting a specific dollar threshold on what amount is considered "nominal," and excluding clinics that condition services on payment (regardless of the dollar amount), this study devised a definition of free clinics that draws a clear line between free clinics and other kinds of ambulatory care safety net providers. These criteria yielded a study population of 1188 free clinics.

SURVEY INSTRUMENT AND ADMINISTRATION

A 70-item, 12-page questionnaire requested information on operations, patients, services, staff and volunteers, and future plans. More than 50 free clinic experts and practitioners, government officials, foundation staff, academics, and health policymakers commented on draft versions. A revised draft survey was pretested at 23 clinics. The final survey booklet contained mostly closed-ended items.

The survey was administered between October 7, 2005, and December 15, 2006. All clinics were contacted at least twice and some up to 6 times. Except in 6 cases, all correspondence was sent to a named individual (typically the clinic director or medical director). Contacts included: (1) FedEx envelope[69] containing the cover letter, survey, and self-addressed stamped envelope; (2) postcard; (3) e-mail/fax; (4) letter with replacement survey and self-addressed stamped envelope; (5) letter with nonmonetary incentive (ie, pen with inscription, "If you've seen one free clinic, you've seen one free clinic"); and (6) telephone call. Survey methods were approved by the School of Social Service Administration/Chapin Hall Institutional Review Board at The University of Chicago.

DATA ANALYSIS

I examined clinics' organizational structure and operations, the number and characteristics of their patients, the number and type of services available on-site, the cost of care, and the number and composition of staff and volunteers. Means were computed for continuous variables and frequencies for categorical variables.

Potential unit nonresponse bias was explored using univariate statistics and multivariate logistic regression analyses of clinic founding year, geography, and population size of areas surrounding the clinic. The extent of item nonresponse was investigated by dividing the frequency of item response by the number of eligible respondents. A "don't know" response was treated as missing. Nonresponse rates of 10% or higher were considered "high."

RESULTS

STUDY POPULATION

Of the 1188 surveys mailed, 945 (79.5%) were returned; of these, 764 clinics (80.9%) were determined eligible for the study and 181 (19.2%) were determined ineligible because they did not meet the study criteria. Clinics were excluded for numerous reasons. The most frequent was that the clinic charged more than the $20 maximum fee determined to be nominal (n=36). In addition, 28 clinics were excluded because they were duplicate entries on the mailing list; 21 because the respondents indicated that the clinic was not a free clinic; 16 because they bill patients; 15 because they serve mostly insured patients; and 13 because they were a FQHC. The remaining 52 exclusions were for various other reasons, such as the clinic was closed, but no single reason accounted for more than 5% of the total number of ineligible clinics. Attempts to reach 15 clinics were unsuccessful; 1 or more mailings were returned undeliverable. The study achieved a 75.9% response rate. Overall, 1007 free clinics are known to exist throughout 49 states and the District of Columbia, with Alaska as the lone ex-

Table 1. Characteristics of Clinics

Characteristic	Free Clinics[a] (N=764)
Hours open per week (n=751)	
Mean (SD)	18.0 (15.2)
Any daytime hours	72.7
Open after 5 PM	67.1
Any weekend hours	15.9
Mean (SD) No. of days open per week	3.0 (1.7)
Type of clinic	
Medical	95.2
Nonmedical	4.8
Year founded (n=758)	
Before 1980	7.4
1980s	10.8
1990s	44.1
2000s	37.7
Mean (SD)	1995.0 (11.1)
Affiliation (n=756)	
None, independent	56.6
Part of another organization	30.2
Affiliate of another organization	13.2
Type of affiliation (n=323)[b]	
Hospital	31.6
Church	26.3
University	10.8
Medical school/center	11.5
Homeless shelter	10.5
Social service agency	15.5
Other	28.8
Clinic facilities (n=734)	
Owned	29.2
Rented	19.4
Donated/borrowed	47.9
Mobile	3.8
Religious, vs secular (n=752)	36.8
Mean (SD) operating budget, $ (n=587)	287 810 (624 884)
Sources of funding (n=748)	
Mean (SD) No. of sources[c]	5.5 (2.6)
Individuals	90.6
Foundations	65.1
Corporations	55.1
Civic groups	66.8
Churches	66.3
Patients	39.7
Hospitals	42.4
United Way	37.3
University or medical school	7.8
Government: federal/state/local	34.8
Third-party payers	4.3
% of Revenue from government (n=728)	
0	58.7
1-24	26.0
25-49	8.5
50-74	4.1
≥75	2.8
Appointments (n=745)	
Schedule	67.3
Walk-in	71.0
Mean (SD) wait time for appointment, d	
New patients	11.9 (17.8)
Established patients	10.6 (36.9)
Uninsured patients only (n=752)	56.4
Income requirements (n=739)	56.5
Residency requirements (n=757)	54.0

[a] Data are presented as the percentage of clinics unless otherwise indicated.

[b] The number exceeds the total number of responding clinics and the percentages exceed 100 because some clinics reported more than 1 type of affiliation. Data are limited to clinics that reported being part of or affiliated with another organization.

[c] The maximum number of funding sources is 14.

ception. In a logistic regression model exploring clinic founding year, geographic region, and population size, no factors were found to be statistically significant predictors of unit nonresponse (results are available from J.S.D.).

Item nonresponse rates exceeding 10% were observed for a small number of items and attributable overwhelmingly to valid "don't know" responses rather than refusals.

ORGANIZATIONAL CHARACTERISTICS

Organizational characteristics provide insight into the operational capacity of free clinics to respond to the health care needs of uninsured residents. Free clinics operate under a range of organizational structures (**Table 1**). Most operate as medical clinics in buildings that are generally rented; a few clinics own their buildings. Most are independent entities. Among affiliated clinics, the most frequently cited affiliation is with a hospital. The mean origination year is 1995; most free clinics have formed since 1990. The mean number of weekly hours that free clinics reported being open to see patients is 18 (median, 11) although weekly hours open varied widely: 215 clinics (28.6%) reported being open 5 or fewer hours per week, and 188 clinics (25.0%) reported being open, on average, 41 hours per week. Clinics are generally open during daytime hours. Most clinics also reported having evening hours. Free clinics reported scheduling appointments (67.3%) and/or allowing walk-in appointments (71.0%). The mean wait time to obtain an appointment for new and established patients is 12 days and 11 days, respectively. These wait times suggest that demand for free care exceeds clinic capacity. Perhaps in response to high demand, more than half of the clinics reported conducting eligibility screening based on insurance status, income, and residency before new patients can qualify to receive services.

Free clinics reported widely ranging operating budgets, with a mean (SD) of $287 810 (624 884) (median, $125 000). Free clinics receive funding from diverse sources, including private charitable donations (90.6% of the clinics), civic groups (66.8%), churches (66.3%), foundations (65.1%), and corporations (55.1%), whereas federal, state, and/or local grants support some of the operating costs for a few free clinics. Overall, 58.7% received no government revenue, and even among the largest clinics (ie, those in the top 25% of annual visits) 43.2% did not report receiving government revenue.

PATIENTS

Free clinics serve patients with attributes that impede their access to primary care: uninsured, inability to pay, racial/ethnic minority, limited English proficiency, noncitizenship, and lack of housing (**Table 2**). These characteristics also increase their risk of poor health outcomes. Free clinics reported serving a mean (SD) of 747.0 (1183.4) new patients per clinic per year and 1796.0 (2872.4) total unduplicated patients. Overall, the 1007 free clinics serve about 1.8 million mostly uninsured patients annually. Free clinics reported providing a mean of 3217.0 (6001.7) medical visits and 825.0 (1367.7) dental visits per clinic per year. Collectively, they are estimated to provide 3.1 million medical visits and nearly 300 000 dental visits annually.

Table 2. Characteristics and Volume of Free Clinic Patients

Characteristic (Total No. of Free Clinics)	Patients[a]
Uninsured (n=671)[b]	92.2 (17.0)
Female sex (n=653)[b]	58.1 (14.1)
Age group, y	
≤17 (n=688)	11.5
18-64 (n=668)	80.1
≥65 (n=672)	7.6
Race/ethnicity[b]	
Latino (n=696)	25.1 (29.3)
White (n=692)	50.1 (31.5)
Black or African American (n=688)	21.2 (21.2)
Asian (n=673)	3.1 (11.1)
American Indian or Alaska Native (n=662)	0.7 (4.2)
Native Hawaiian or Pacific Islander (n=655)	0.3 (1.9)
Income, % of poverty level[b]	
<100 (n=541)	56.1 (35.4)
100-200 (n=539)	40.8 (34.5)
>200 (n=546)	3.2 (10.6)
Special populations (n=750)	
Homeless	41.9
Immigrants	39.3
Substance abuse disorder	18.5
Human immunodeficiency virus/AIDS	9.5
Mean No. of new patients (n=524)	747.0 (1183.4)
Mean No. of unduplicated patients (n=534)	1796.0 (2872.4)
Total No. of medical visits (n=589)	3217 (6001.7)
Total No. of dental visits (n=200)	825 (1367.7)

[a] Data are given as the percentage of patients unless otherwise indicated.
[b] The percentages represent the reported mean (SD) percentage of patients who share the particular patient characteristic. For example, at an average clinic, the percentage of patients who are reported to be female is 58.1.

SERVICES

The scope of services available on-site and by referral provides information about the extent to which free clinics are equipped to handle patients' health problems. Clinics were provided a list of 22 types of services and asked to specify whether each service was offered on-site, by referral, or not available. Overall, free clinics provide a fairly limited range of primary care services, reproductive health services, and services for other selected health conditions on-site (**Table 3**). The mean number of services is 8.4 (median, 8.0). Most free clinics provide medications (86.5%), physical examinations (81.4%), health education (77.4%), chronic disease management (73.2%), and urgent/acute care (62.3%). Clinics open full-time offer the broadest scope of services, with most supplementing the aforementioned services with gynecological care (73.0%), laboratory services (55.8%), case management (56.9%), vision screening (53.5%), and tuberculosis care (51.7%). Except for the 188 full-time clinics (25.0%) that offer comprehensive services, free clinics do not appear to be an appropriate substitute for other comprehensive primary care providers. This is especially true for women because most free clinics do not directly provide any reproductive health services (eg, only 46.2% offer gynecological care). Most free clinics reported offering medications from a dispensary (65.9%) rather than a licensed pharmacy (25.3%), including free samples obtained from pharmaceutical manufacturers (86.8%), pharmaceuticals purchased with the assistance of corporate patient assistance programs (77.3%), direct purchases from manufacturers (54.9%), or outside pharmacies (52.2%). Free clinics reported using individual volunteer health care providers (34.5%); community health care providers such as health centers, health departments, and public hospitals (53.8%); and health care providers from a single hospital or physician group (31.1%) to deliver free services unavailable on-site. Among all responding clinics, the mean annual number of referrals is 362 (median, 118).

Table 3. On-Site Services

On-Site Service	Free Clinics[a]
Mean (SD) No. of services (n=716)[b]	8.4 (4.0)
Primary care services (727 medical clinics)	
Physical examination	81.4
Urgent/acute care	62.3
Immunizations	36.6
Laboratory	43.9
Radiography	8.8
Chronic disease management	73.2
Vision screening	34.4
Reproductive health services (727 medical clinics)	
Family planning	19.8
Prenatal/obstetrical	7.4
Gynecological	46.2
Selected conditions	
Sexually transmitted diseases (727 medical clinics)	29.7
Human immunodeficiency virus/AIDS (727 medical clinics)	23.1
Tuberculosis (727 medical clinics)	34.0
Mental health (730 medical and other clinics)	30.0
Substance abuse (730 medical and other clinics)	8.5
Other services	
Specialty (727 medical clinics)	23.9
Dental (764 clinics)	34.6
Eyeglasses (727 medical clinics)	11.1
Case management (727 medical clinics)	41.7
Health education (727 medical clinics)	77.4
Alternative therapies (730 medical clinics)	19.7
Medications (739 medical, other, and pharmacy clinics)	86.5
Pharmaceutical facilities (671 clinics)[c]	
Licensed pharmacy	25.3
Dispensary	65.9
Medication arrangements (661 clinics)[d]	
Physician samples	86.8
Pharmaceutical company patient assistance program	77.3
Purchase medications	54.9
Pay outside pharmacy	52.2
Stock bottles	49.8
Bulk donation	21.5
Other	15.8
Mean (SD) No. of referrals to providers (420 clinics)	362 (724)

[a] Data are given as the percentage of clinics unless otherwise indicated.
[b] The maximum number of services is 22.
[c] Clinics may have reported having more than 1 type of facility.
[d] The sample of clinics includes only those that reported providing medications.

COST

The minimum amounts charged by private physicians, health centers, and public clinics are considerably more than the $9.30 mean fee/donation requested by 45.9% of free clinics; 54.1% of free clinics charge nothing (**Table 4**). The commitment to making free or low-cost health care available extends even to services many

Table 4. Cost of Care

Characteristic	Free Clinics
No fees/donation	
Medical[a]	54.1
Dental[b]	46.6
Medications[c]	55.8
Laboratory[a]	80.7
Radiography[a]	63.4
Mean (SD) fee/donation, $[d]	9.30 (9.9)

[a] The sample of clinics includes only medical clinics (n=727). Of the 727 eligible clinics, 703 (96.7%) responded to the laboratory services item and 691 (95.0%) to the radiography item.
[b] The sample of clinics includes only dental clinics (n=264).
[c] The sample of clinics includes only clinics that reported providing medications (n=739). Of the eligible clinics, 669 clinics (90.5%) responded to the item.
[d] The sample of clinics includes only those that specified the amount of the fee or suggested donation (n=107).

free clinics do not themselves offer. For example, most free clinics reported making arrangements for patients to receive free laboratory and radiographic services (80.7% and 63.4%, respectively), although few offered these services on-site (laboratory, 43.9%; radiography, 8.8%).

STAFF AND VOLUNTEERS

Free clinics' service capacity can be measured, in part, by who is providing care (**Table 5**). The status of staff and providers (paid or volunteer) provides insight into the clinic's permanency, potential responsiveness to as-yet-unmet needs, and ability to expand. Nearly all clinics reported that volunteer health care professionals provided some health care services (97.7%). The mean annual number of volunteer hours per clinic was 4237 (median, 2087). This mean equates to 2.4 volunteer hours per patient (including clinical services and administrative functions). Among volunteers, the health care provider type cited most frequently is physician (82.1%), 95.0% of whom are board certified. Free clinics also reported using other volunteer health professionals, including nurses (72.6%) and nurse practitioners/physician assistants (54.9%). There were fewer social workers (25.6%) and psychologists (12.0%) in volunteer positions. More than three-quarters of the clinics reported using paid staff (77.5%), either full-time (54.6%) or part-time (61.1%). Notably, about two-thirds employ a paid executive director (65.8%), and about half pay administrative staff (48.9%).

Table 5. Characteristics of On-Site Free Clinic Staff and Volunteers

Characteristic	Free Clinics[a]
Volunteers (n=743)	
Any volunteers[b]	97.7
Mean (SD) volunteer hours per clinic (n=531)	4237.0 (6489.1)
Paid staff (n=743)	
Any paid staff	77.5
Full-time paid	54.6
Part-time paid	61.1
Mean No. of paid staff	2.7
Executive director (n=743)	
Full-time paid	43.2
Part-time paid	22.6
Volunteer	27.1
Physicians (n=708)[c]	
Full-time paid	6.8
Part-time paid	12.6
Volunteer (n=583)	82.1
Mean (SD) board-certified (n=590)[c]	95.0 (18.4)
Nurses (n=708)[c]	
Full-time paid	18.1
Part-time paid	20.5
Volunteer	72.6
Nurse practitioners/physician assistants (n=708)[c]	
Full-time paid	14.1
Part-time paid	16.2
Volunteer	54.9
Pharmacists (n=654)[d]	
Full-time paid	3.2
Part-time paid	8.1
Volunteer	40.4
Social workers (n=711)[e]	
Full-time paid	7.0
Part-time paid	5.9
Volunteer	25.6
Psychologists (n=711)[e]	
Full-time paid	1.1
Part-time paid	2.2
Volunteer	12.0
Administrative staff (n=743)	
Full-time paid	26.0
Part-time paid	22.9
Volunteer	35.7

[a] Data are given as the percentage of clinics unless otherwise indicated. Percentages are based on the percentages of clinics that wrote in any value greater than 0. Blank cells were interpreted as 0 (ie, not having any staff/volunteers). Therefore, the reported percentages may underestimate the extent of paid staff and volunteer support. To partially adjust for potential underestimation, clinics that skipped the entire question were excluded (n=21).
[b] The percentage of clinics using volunteers was computed by summing the percentage of clinics that reported having volunteers or reported a value greater than 0 for the number of volunteer hours.
[c] The sample of clinics includes only medical clinics (n=727).
[d] The sample of clinics includes only clinics that reported providing medications (n=739).
[e] The sample of clinics includes only medical clinics and other clinics (n=730).

COMMENT

To my knowledge, this study is the first systematic (ie, definitionally rigorous and sectorally comprehensive) overview of free clinics in 40 years. Its results depart substantially from those of a 2005 national free clinic survey,[65] with the most likely explanation being the different methods used in the present study. Unlike the previous survey, the present study used numerous disparate data sources to identify the population of free clinics, applied uniform criteria based on a standard definition to evaluate eligibility, and elicited comprehensive information from 764 clinics based on a census of all known free clinics.

Because they relied on a single source—the National Free Clinic Directory, a directory of self-identified free clinics—to identify their sample (n=355), Nadkarni and Philbrick's 2005 free clinic survey[65] is vulnerable to undercoverage and voluntary selection bias. Because they did not verify the status of the clinics listed in the directory, their results are biased because some clinics that are included among the respondents are not, in fact, free clinics. My re-

Table 6. Comparing Free Clinics With Health Centers

Clinic Type	No. of Uninsured Patients	Budget	Cost of Care per Patient, $	Primary Care Services	Health Care Providers	Average Cost to Uninsured Patient
Free clinics	1.8 Million[a]	$290 Million (all sources)[c]	600[e]	Basic, plus medications	Mostly volunteer	$9.30[g]
Health centers	6 Million[b]	$1.8 Billion federal appropriation[d]	562[f]	Comprehensive, medications often available at reduced cost	Paid staff	$5-$24 for patients with income below 100% of the poverty level; $47 at 150%; and $87 at 200%[h]

[a] Estimated based on the reported mean number of unduplicated patients (n=1796).
[b] Data available at http://bphc.hrsa.gov.
[c] Estimated based on the reported mean budget ($287 810) and number of known free clinics (1007).
[d] US Department of Health and Human Services budget in brief for 2007. About one-fifth of health center revenue comes from the federal health center grant.
[e] http://www.hrfreeclinic.org/sections/statistics/; data are not available for all free clinics.
[f] According to an e-mail from Michelle Proser, MPP, National Association of Community Health Centers, on October 19, 2009. The estimate comes from Table 8A of the Uniform Data System[71] and is based on total costs divided by the total number of patients.
[g] $9.30 Among clinics that charge nominal fee/collect donations.
[h] Gusmano et al[12] and Weiss et al.[11]

view of the directory revealed that 54 of the clinics listed in the source do not meet the definitional criteria used in this study. Some clinics on the list are FQHCs (n=19); charge more than $20, bill patients, or deny/reschedule care if a patient cannot pay (n=28); serve mostly insured patients (n=3); are "free clinics without walls" (n=1); or are public clinics (n=3). If all 54 clinics actually participated in the Nadkarni and Philbrick survey, nearly 20% of their sample (281 [19.2%]) would be contaminated with clinics that are not strictly free clinics.

The present description suggests that free clinics are a much more important component of the ambulatory care safety net than generally recognized. For instance, the Institute of Medicine's seminal study on the safety net[70] did not mention free clinics. The present results suggest that this is a major oversight in a context where more than 1000 free clinics are estimated to serve 1.8 million mostly uninsured patients and provide more than 3 million medical visits annually. These numbers may be compared with the 6 million uninsured (of 15 million total) served in 2006 by the $1.8 billion federal health center program (http://bphc.hrsa.gov).

Free clinics tend to serve similar patients (mostly uninsured, nonelderly adults; women; and minorities with low incomes) but have diverse organizational structures, operations, scopes of services, and compositions of staff. This diversity suggests that there is a high degree of variability across the sector in terms of individual clinics' capacity to satisfy the basic health care needs of uninsured patients. All clinics rely extensively on volunteer licensed health care professionals to deliver services and on private donations for operating budgets, 2 conditions that impede expansion efforts.

The niche that free clinics occupy in the ambulatory health care safety net may be appreciated more fully by comparing free clinics with health centers, which have been the focus of our health care delivery solutions for the poor and uninsured. Operating with smaller (mostly privately financed) budgets, free clinics provide a more limited scope of services, use mostly volunteers, and charge patients little or nothing (**Table 6**).

Free clinics suggest an alternative model of primary care to the underserved, and the merits of the free clinic model ought to be discussed as viable options to serve the uninsured. The limited data about the quality of care provided by free clinics constrains the debate, but it is worth noting that a recent study of a volunteer-based free clinic that is open just 2 nights per week documented clinically meaningful improvements in chronic disease outcomes after adopting the chronic care model.[49]

Of interest, study findings challenge the belief that free clinics would be phased out if comprehensive health insurance reform were enacted.[67] This belief rests on several assumptions: that there would be no coverage gaps; that free clinics are "temporary"; that patients, if given a choice, would not choose free clinics; and that free clinics would not be interested in participating in third-party programs. This study suggests otherwise. Throughout their history, free clinics have served as gap-fillers, targeting patients who are underserved by mainstream medicine. They also focus on providing services less readily available elsewhere, such as medications, eyeglasses, and health education. Hundreds of free clinics have existed for a decade or more, employ staff, own their premises, manage a budget of more than $750 000, and serve thousands of patients annually. In response to universal insurance, it would seem likely that these clinics would adapt rather than close. There is some evidence to suggest that newly insured patients would return to free clinics. Although most free clinics currently exclude the insured, a mean of 7.5% of free clinic patients actually do have insurance. Therefore, these patients probably have alternative sources of care and nevertheless select free clinics. In addition, the survey data suggest that free clinics may be interested in participating in third-party insurance programs once their insured caseload is large enough to warrant participation. For example, in the highest-volume clinics (top 10% of annual visits), 8 (13.1%) reported billing insurers vs only 1 clinic in the bottom 10%.

Some study limitations should be acknowledged. Sampling bias could have occurred if existing free clinics were not included in the cases examined, but this likelihood was reduced because the population was surveyed. In addition, clinics were identified using numerous disparate sources. Nevertheless, the smallest, youngest, and least formal free clinics were more likely to be excluded.

To reduce item nonresponse bias and measurement error, rigorous pretest procedures were adopted to extract poorly worded questions or response categories. Partially closed responses were used to lessen the possibility of systematic biases resulting from loaded questions.

The cross-sectional design can suggest associations between variables, but cannot establish causality. Also, only free clinics that were currently operating were described.

The findings should stimulate further academic inquiry. Research is needed to assess changes in the sector over time, care quality, and the reasons why patients choose (or end up in) free clinics. Longitudinal data collection and analysis should be a top research priority.

CONCLUSIONS

Free clinics provide a range of preventive and general medical care for an estimated 10% of the working-age adult uninsured population who seek care.[72,73] In light of free clinics' population reach, service limits, and staffing and financial constraints coupled with their extensive practice of making referrals and collaborating with safety net providers for diagnostic services and specialty care, a prudent next step would be to establish federal or state demonstration programs to promote and evaluate collaborations between free clinics and other safety net providers. Any new demonstration program must be designed to avoid the pitfalls of the Healthy Community Access Program, a federal demonstration program that aimed to improve access to care through coordinated delivery systems but, ultimately, was judged "ineffective," largely because of its unclear purpose, poor design, and lack of accountability.[74] Free clinics have passed the point in history when they can exist below the radar. At the same time, policymakers and other safety net providers must acknowledge the important role that free clinics play. Formal integration of free clinics into the safety net has the potential to strengthen the overall health system, which is important regardless of the outcome of the national health reform debate.

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Correspondence: Julie S. Darnell, PhD, MHSA, Division of Health Policy and Administration, School of Public Health, University of Illinois at Chicago, 1603 W Taylor St, Room 754, M/C 923, Chicago, IL 60612 (jdarnell@uic.edu).
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INVITED COMMENTARY

Free Clinics

A Personal Journey

More than 46 million Americans have no health insurance, and the number is steadily growing. To meet the health care needs of the uninsured, a safety net has evolved of public health clinics, federally qualified health centers, emergency departments, and hospital outpatient clinics. In the article *Free Clinics in the United States: A Nationwide Survey,* the first comprehensive assessment of free clinics in 40 years, Darnell demonstrates that free clinics are an important but marginalized contributor to the safety net. With a national plan to expand health insurance passed by Congress and signed by President Barack Obama, some may mistakenly think that free

clinics will no longer be needed. However, it is clear that the health care expansion will not cover all of the uninsured and will take several years to put into practice. Free clinics will be there to catch those who fall through these gaps.

While the study by Darnell provides an excellent assessment of free clinics in the United States, hard to capture in a quantitative study is the individuality of free clinics; just as no 2 patients, even 2 with the same disease, are the same, no 2 free clinics are exactly the same. Part of why there is so much diversity is that each free clinic starts in a different way. To better understand the development and purpose of free clinics, we tell the story of our free clinic, the San Francisco Free Clinic.

Twenty years ago, we were 2 young family physicians just out of residency starting a private practice in San Francisco. Despite not knowing how to run a business or even submit a bill, we were surprisingly successful. In just 3 years we had paid for an outfitted clinic, our staff was well paid, and we were taking home some money ourselves. But 1 thing bothered us. We could not afford to accept Medicare or Medicaid patients, and it was painful asking the many patients with no insurance to pay cash. At the time, nearly 1 in 5 San Franciscans were uninsured. Yet the city had more physicians per capita than most locales. Something seemed wrong. A large number of physicians were competing for patients with insurance, while a large number of patients were uninsured and had trouble finding physicians to care for them.

This led to a brainstorm. Would it not be better to practice in the population that needed us most? We would only see patients with *no* insurance and repaint the shingle to read *Free Clinic*. We soon discovered, however, that there was so much to do. We would have to be a nonprofit organization or no one could donate money. That meant finding a board of directors. And where would the money come from? Did we really want to trade hospital rounds for writing complex government grants? How would our patients undergo laboratory studies, x-rays, or a specialty consult? Which hospital would accept our admissions? Would all our patients be homeless? Would we pay ourselves, and if so, how much?

They say that wisdom comes from asking the question, not from being certain of the answer. One by one we found solutions. In that process, we stumbled onto a project so simple and satisfying that it has been the gift of a lifetime, not only for us but also for the community who became a part of it.

Regarding a board of directors, the head of a large foundation gave us great advice. "Find heavy hitters for your board, not talkers. Their job is to raise money." We formed a small board of sympathetic folk who worked in finance and banking, and included a couple of physicians for good measure.

In considering government grants, it became apparent that we did not want public money at all. The applications are long and complex, and much of each dollar is spent in reporting requirements. Private foundations are simpler by far. We could write these ourselves and avoid hiring grant-writing professionals.

Our enthusiasm came down a notch with our first grant application. We were told that new nonprofit organizations are numerous and most quickly fold. We had to show a base of support—not 2 or 3 people but a population who support our project. Where would we find a base of support? Then we remembered; we were already connected to a group, our local medical society, the San Francisco Medical Society.

We wrote a letter to every physician in our membership book. The outpouring of help was tremendous, not only from physicians but also from imaging centers and hospitals. We went back to the foundation with our newfound wealth, and after receiving the first grant, others followed.

The clinic became a wonderful example of how the medical community, private charities, and business foundations can come together to help people with no health insurance. The structure of the clinic is unique. No bills are generated, and we do not apply for complex government grants. This eliminates the need for administrative staff and assures that everyone at the clinic is involved in patient care. All staff are paid, which gives us the stability of a private practice. More than 100 specialists donate 1 or 2 consults per month in their office, and imaging centers and hospitals each perform a small number of x-rays, computed tomographic scans, and magnetic resonance imagings. For admissions, we are blessed by one of the finest county hospitals in the world. Our golden rule is 2-fold: have many people give only a little bit each, and never allow complexity to enter the project. No provider has dropped out in 16 years. When we tally the value of donated time and supplies, we can honestly tell funders that every real dollar is stretched 3-fold by the medical community. Furthermore, 100% of donations go directly to patient care. Funders are fond of these principles, and they tend to repeat gifts year after year.

The clinic is a happy place. The staff feels good about helping those in need, and we appreciate the freedom to focus on patients. The specialists seem pleased to donate expertise and funders know their money is well used. Most important, patients say "thank you." And who are the patients? They are neighbors, families, students, the self-employed, small business folk, or people who recently lost their jobs. They are people we know and see everyday.

As Darnell suggests, many free clinics will integrate into the funding and billing network that will come with extending insurance coverage while others will remain the safety net for those excluded from federal reform efforts. Until we have true universal coverage, clinics will be needed where the uninsured can receive the care that all people deserve.

Richard D. Gibbs, MD
Patricia H. Gibbs, MD

Author Affiliations: San Francisco Free Clinic and Department of Family and Community Medicine, University of California–San Francisco.
Correspondence: Dr R. D. Gibbs, San Francisco Free Clinic, 4900 California St, San Francisco, CA 94118 (rgibbs@sffc.org).
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