CENTER for STUDYING HEALTH SYSTEM CHANGE

Tracking Report

ACCESS TO CARE

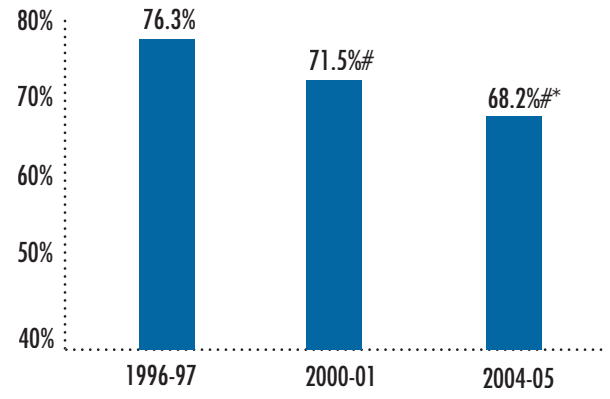
RESULTS FROM THE COMMUNITY TRACKING STUDY • NO.13 • MARCH 2006

A Growing Hole in the Safety Net: Physician Charity Care Declines Again

By Peter J. Cunningham and Jessica H. May

Continuing a decade-long trend, the proportion of U.S. physicians providing charity care dropped to 68 percent in 2004-05 from 76 percent in 1996-97, according to a national study from the Center for Studying Health System Change (HSC). The ongoing decline in physician charity care is alarming given the increase in the number of uninsured people, particularly during the first half of the decade. Declines in charity care were observed across most major specialties, practice types, practice income levels and geographic regions. Increasing financial pressures and changes in practice arrangements may account in part for the continuing decrease in physician charity care.

Figure 1: **Percent of Physicians Providing Charity Care**



* Change from 2000-01 is statistically significant at p <.05.
# Change from 1996-97 is statistically significant at p <.05.
Source: Community Tracking Study Physician Survey

PHYSICIAN CHARITY CARE CONTINUES TO DECLINE

Physicians have long played a key role in the nation's health care safety net, providing free or reduced cost care to uninsured patients in their own practice or as volunteers at free clinics. However, financial and time pressures, as well as ongoing changes in the medical marketplace, may be contributing to decreases in the proportion of physicians providing charity care. The percentage of physicians providing any free or reduced cost care decreased to 68.2 percent in 2004-05 from 71.5 percent in 2000-01, according to HSC's nationally representative Community Tracking Study Physician Survey (see Data Source). This trend dates back to at least 1996-97, when more than three-fourths (76.3%) of physicians provided some charity care (see Figure 1 and Table 1).

Despite a decrease in the proportion of physicians providing charity care, the actual number of physicians providing charity care has remained relatively stable because the overall number of practicing U.S. physicians increased from approximately 347,000 in 1996-97 to 397,000 in 2004-05. Additionally, among physicians who provide charity care, there was little change in the amount of charity care provided during this period. From 1996-97 to 2004-05, the average number of hours spent providing charity care and the percentage of practice time spent on charity care both declined slightly, but these changes were not statistically significant.

Nevertheless, there has been a decline in the amount of physician charity care relative to the number of uninsured Americans. The overall number of charity care hours per 100 uninsured people declined from 7.7 hours in 1996-97 to 6.3 in 2004-05, an 18 percent decline.[1] Most of this decrease has occurred since 2000-01, primarily because of large increases in the number of uninsured, from 39.6 million in 2000 to 45.5 million in 2004.

PHYSICIAN SPECIALTY

The proportion of physicians providing charity care declined across all major specialty groups (see Table 2), as well as across all geographic regions and in both urban and rural areas (latter findings not shown). Surgical specialists are the most likely among specialty physicians to provide charity care, probably because many are required to be on call at hospitals and therefore have less choice about whether to treat uninsured patients. Pediatricians are the least likely to provide charity care, which perhaps reflects the fact that fewer children are uninsured because of more generous public coverage eligibility compared with adults.

PHYSICIAN PRACTICE CHARACTERISTICS

Charity care is declining across most types of physician practices, and physicians are increasingly moving to practice settings where there is less provision of charity care.

Levels of charity care are highest among physicians in solo or small group practices and those that are full or part owners of their own practice, perhaps because they have greater control over the types of patients they see and there are fewer organizational barriers for uninsured persons to see these physicians. About 80 percent of physicians in solo practice or small groups (10 physicians or fewer) provided charity care in 2004-05, and this has not changed significantly since 1996-97.

By comparison, physicians in larger groups and institutional-based practices (i.e. medical schools or hospitals) are much less likely to provide charity care, and charity care among these physicians declined sharply between 1996-97 and 2004-05. Furthermore, a decreasing number of physicians are in solo practice, and an increasing number of physicians are practicing in the practice settings that are less likely to provide charity care. Between 1996-97 and 2004-05, the percentage of physicians in solo or two-physician practices declined from 40 percent to 31 percent, while the percentage in large groups, hospitals, and medical schools increased from 21 percent to 26 percent (findings not shown).

Similarly, physicians who own their practice are more likely to provide charity care than nonowners (who are more likely to be in large practices and institutional settings). While charity care decreased between 1996-97 and 2004-05 for both owners and nonowners, the percentage of physicians who are full or part owners has been steadily decreasing, from about 62 percent in 1996-97 to 54 percent in 2004-05.

TABLE 1: **Physician Charity Care, 1996-97 to 2004-05**

	1996-97	2000-01	2004-05
Number of U.S. Physicians (thousands)	347	379	397
Percent of Physicians Providing Any Charity Care in Previous Month	76.3	71.5#	68.2*#
Average Number of Hours Providing Charity Care, if Any	11.1	11.0	10.6
Percent of Practice Time Spent on Charity Care, if Any	6.7	6.5	6.3

* Change from 2000-01 is statistically significant at p <.05.
\# Change from 1996-97 is statistically significant at p <.05.
Source: Community Tracking Study Physician Survey

PHYSICIAN INCOME

Provision of charity care has declined for physicians at all levels of income. Physicians at the highest income levels continue to report the greatest provision of charity care, with 75.6 percent of physicians with practice incomes greater than $250,000 providing charity care in 2004-05, compared with 66.4 percent of physicians earning less than $120,000. However, physician income has declined in real terms in recent years, both for primary care physicians and specialists, likely because of constraints on public and private reimbursement levels.[2] Declining practice incomes likely make it more difficult for physicians to subsidize charity care.

LOCATION OF CHARITY CARE

The majority of physicians who provided charity care (more than 70%) reported that they typically did so in their own practice (see Table 3). About 14 percent of physicians reported providing charity care primarily while on call in a hospital

Data Source

This Tracking Report presents findings primarily from the HSC Community Tracking Study Physician Survey, a nationally representative telephone survey of physicians involved in direct patient care in the continental United States conducted in 1996-97, 1998-99 (results not shown for ease of presentation), 2000-01 and 2004-05. The sample of physicians was drawn from the American Medical Association and the American Osteopathic Association master files and included active, nonfederal, office- and hospital-based physicians who spent at least 20 hours a week in direct patient care. Residents and fellows were excluded. The 1996-97, 1998-99 and 2000-01 surveys each contain information on about 12,000 physicians, while the 2004-05 survey includes responses from more than 6,600 physicians. The response rates ranged from 52 percent to 65 percent.

In addition, this Tracking Report presents findings from the HSC Community Tracking Study Household Survey, a nationally representative telephone survey of the civilian, noninstitutionalized population. Data were supplemented by in-person interviews of households without telephones to ensure proper representation. The 1996-97 and 2000-01 surveys each contain information on about 60,000 persons, while the 2003 survey includes responses from about 46,600 persons. The response rates ranged from 57 percent to 60 percent. More detailed information on survey methodology can be found at *www.hschange.org*.

ONLINE

CTSonline, a Web-based interactive system for results from the CTS Physician Survey, is available at *www.hschange.org*.

TABLE 2: **Physicians Providing Any Charity Care, by Physician Characteristics**

	1996-97	2000-01	2004-05
All Physicians	76.3%	71.5%#	68.2%#*
Specialty			
General Internal Medicine	71.2	67.0*	67.2
Family/General Practice	77.0	74.6	66.7#*
General Pediatrics	65.1	65.1	60.5
Medical Specialists	74.8	66.8#	63.7#*
Surgical Specialists	83.1	80.9	78.8#
Practice Type			
Solo/Two Physicians	83.9	80.6#	81.8
Small Group Practice	81.2	79.8	78.5
Group - 11-50 Physicians	76.5	71.3#	66.2#
Group - 50+ Physicians	73.3	67.5	61.9#
Group/Staff HMO	45.1	39.9	35.8
Medical School	74.1	63.8#	54.6#*
Hospital	66.3	59.4#	54.5#
Other	64.0	62.1	54.4#*
Ownership			
Full or Part Owner	83.0	80.5#	78.2#*
Non-Owner	65.6	60.2#	56.4#*
Physician Income in Year Prior to the Interview			
< $120,000	72.6	68.6#	66.4#
$120,000-$250,000	74.7	68.7#	65.0#*
> $250,000	82.6	80.7	75.6#*

* Change from 2000-01 is statistically significant at p <.05.
\# Change from 1996-97 is statistically significant at p <.05.
Source: Community Tracking Study Physician Survey

emergency department, about 6 percent in another practice or clinic (e.g. as volunteers at a free care clinic), and 8.4 percent at another unspecified location.

Pediatricians and family practice physicians are the most likely among major specialty groups to provide charity care at their main practice. Medical and surgical specialists are the most likely to provide charity care as a result of their on-call responsibilities at hospitals, although most specialists report that their own practice is the place where they typically provide charity care.

DECLINES IN ACCESS TO MEDICAL CARE

The long-term decline in charity care provided by physicians may have contributed to reductions in uninsured people's access to medical care. In 2003, 63.1 percent of the uninsured had a regular source of medical care, down from 68.6 percent in 1996-97 (see Table 4). Additionally, the percentage of the uninsured with a physician visit in the past year fell from 51.6 percent to 46.1 percent during this period.

Emergency department visits as a proportion of all ambulatory visits increased for the uninsured between 1996-97 and 2000-01, as did the proportion of uninsured people with unmet medical needs. However, the downward trend in access leveled off between 2000-01 and 2003, and even improved in terms of unmet medical needs. Continued declines in physician charity care during the early 2000s may have been offset to some extent by the strengthening of the safety net in some communities, especially the expansion of federally supported community health centers.[3]

IMPLICATIONS

Physicians and hospitals historically have provided charity care to the uninsured in part by charging higher fees to other patients, particularly those with private insurance coverage. But both public and private payers have held the line on reimbursements to medical providers, creating financial pressures that may be limiting physicians' ability to provide charity care.

Hospital uncompensated care levels have held steady in recent years, aided by hospitals' private insurance payments rising somewhat faster than costs.[4] However, declining practice incomes among physicians suggest that they have been less successful than hospitals in negotiating fees with private payers, and they also have experienced continued constraints from public payers. Time pressures for physicians also have increased, in part because of a strong surge in demand for physician services during the late-1990s.[5] As a result, the decline in charity care between 1996-97 and 2004-05 may reflect physicians who believe they can no longer afford or have time to provide charity care.

The movement toward larger practice arrangements and less ownership is also contributing to a decrease in charity care, although this shift may be a response in part to financial and time pressures that physicians are experiencing. Larger practices in which physicians are employees can help shield them from these pressures, provide more leverage in negotiating fees with private payers, and relieve them from some of the burden of on-call responsibilities. However, larger practices also may present greater organizational barriers to uninsured patients, and employed physicians have less discretion over the types of

TABLE 3: **Typical Location of Charity Care, 2004-05**

	In Own Practice	On-Call at Hospital ED	Other Practice or Clinic	Other
All Physicians Who Provide Charity Care	71.2%	13.9%	6.4%	8.4%
Specialty				
General Internal Medicine	73.2	13.6	4.3	9.0
Family Practice	80.8	3.9	7.1	8.3
Pediatrician	85.9	2.8	4.4	6.9
Medical Specialists	66.7	14.5	6.9	11.9
Surgical Specialists	67.0	21.7	7.0	4.4

Source: Community Tracking Study Physician Survey

TABLE 4: **Trends in Access to Medical Care Among the Uninsured**

	1996-97	2000-01	2003
Regular Source of Medical Care	68.6%	64.1%#	63.1%#
Physician Visit	51.6	46.6#	46.1#
Emergency Department Visits as a Percent of Ambulatory Care Visits	18.7	22.1#	20.7
Unmet Medical Need	13.5	15.0#	13.2*

** Change from 2000-01 is statistically significant at p <.05.*
 # Change from 1996-97 is statistically significant at p <.05.
Source: Community Tracking Study Household Survey

patients they see.

The result is that the uninsured likely must rely even more on formal safety net providers, such as community health centers, other free clinics and public hospitals; or they are getting less medical care. This also implies a shift in the financial burden of providing care to the uninsured from physicians to taxpayers in the form of direct and indirect subsidies to major safety net providers. The expansion of federally supported community health centers in recent years may have helped to stem the decline in access to care among the uninsured that was observed during the late-1990s, although overall federal spending on the safety net—while increasing—has not kept pace with the growing number of uninsured.[6] Unless there are steps taken to halt and even reverse increases in the number of uninsured, it is likely that safety net resources will become even more constrained as a result of increased demand. ■

NOTES

1. The overall number of charity care hours per 100 uninsured people was computed as the ratio of the total weighted number of charity care hours provided (based upon the Community Tracking Study Physician Survey) to the total number of uninsured, and multiplied by 100. The total number of uninsured is based on the Current Population Survey (Fronstin, Paul, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2005 Current Population Survey,* Issue Brief No. 287, Employee Benefit Research Institute (November 2005)).

2. Reed, Marie C., and Paul B. Ginsburg, *Behind the Times: Physician Income, 1995-1999*, Data Bulletin No. 24, Center for Studying Health System Change, Washington, D.C. (March 2003). A forthcoming publication from the Center for Studying Health System Change shows a similar trend in declining physician income in real terms across specialties for the period 1995-2003.

3. Hoadley, John F., Laurie E. Felland and Andrea B. Staiti, *Federal Aid Strengthens Health Care Safety Net: The Strong Get Stronger,* Issue Brief No. 80, Center for Studying Health System Change, Washington, D.C. (April 2004).

4. Dobson, Allen, Joan DaVanzo and Namrata Sen, "The Cost-Shift 'Hydraulic:' Foundation, History, and Implications," *Health Affairs,* Vol. 25, No. 1 (January/February 2006).

5. National Center for Health Statistics, *Health, United States 2005* (Table 88), Hyattsville, Md. (2005).

6. Hadley, Jack, et al., *Federal Spending on the Health Care Safety Net from 2001-2004: Has Spending Kept Pace with the Growth in the Uninsured?* The Urban Institute (November 2005).

CENTER for STUDYING HEALTH SYSTEM CHANGE

Tracking Reports are published by the Center for Studying Health System Change.

President: Paul B. Ginsburg
Vice President: Jon Gabel

Contact HSC at:
600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512
Tel: (202) 484-5261
Fax: (202) 484-9258
www.hschange.org