

Small Town Health Care Safety Nets

Preliminary Report on a Pilot Study

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Executive Summary ¹

Although the percentage of rural residents with inadequate health insurance is at least as high as the national percentage, very little is known about rural safety net access. The purpose of this pilot study was to start building knowledge about the rural health care safety net. The study focus was on the primary care safety net in small towns where there is no publicly subsidized charity care. In these towns, the primary care safety net – if there is one – is composed of the private primary care practices. We call this the *informal safety net* — the private professionals and organizations that provide free and low-cost care to people unable to pay but do not receive any public funds or other public support to compensate them for these services.

Because the medically needy in many small rural towns rely on the informal safety net for primary care, it is important that health policy makers have accurate information about that safety net. Important first questions to be answered are whether the un- and underinsured are able to get needed health care in these small towns and whether private safety net providers can afford to provide safety net care.

This research project was a collaborative undertaking of the federal Office of Rural Health Policy and four of the rural health services research centers funded by that office.² In 1999, the investigators conducted community case studies of eight small towns, interviewing key informants in each community. Seven study communities had no primary care practices which were publicly subsidized to provide charity care and, for comparison purposes, one community had a primary care practice which had a charity care subsidy. The eight study communities were a convenience sample, with each of the four participating rural health research centers selecting the study communities in its region according to established selection criteria.

¹ The other investigators in this study were Lynn Blewett, Michelle Brasure, Kathleen Thiede Call, John Gale, Amy Hagopian, L. Gary Hart, David Hartley, Peter House, Kerry James, and Thomas Ricketts. All are co-authors of the studies to be published from this research project. Pat Taylor takes full responsibility for the interpretations of data and the conclusions in this preliminary report. She can be contacted by telephone at 202.543.2605 and e-mail at > ptaylor@cpcug.org <.

² The collaborating research centers were the Maine Rural Health Research Center, University of Southern Maine, the University of Minnesota Rural Health Research Center, the North Carolina Rural Health Research and Policy Analysis Center, University of North Carolina at Chapel Hill, and the WWAMI Rural Health Research Center, University of Washington.

The principal questions addressed in this study were:

- C What percent of the local population needs access to safety net primary care?
- C Are people in need of safety net care able to get it?
- C How much safety net care do the private primary care practices provide?
- C What is the financial impact on the private primary care practices of providing safety net care?

Summary of Key Findings

How many people in these communities needed access to safety net primary care?

The investigators were able to get a solid estimate of the percent of local people who needed access to safety net care in only one study community. However, it was clear in every community that a substantial percentage of the population either had no health insurance or had policies with high deductibles relative to their incomes. The number of underinsured people was estimated by key informants in all communities to be at least equal to the number who were uninsured. The estimated percent of townspeople with inadequate health insurance in the study communities ranged from 20 percent to 40 percent.

Were those in need of safety net care able to get it?

The answer is a qualified ‘yes’ in six of the seven study communities with no publicly subsidized charity care. One community’s sole primary care practice saw only insured patients and those uninsured patients able to pay cash. The other 12 private practices interviewed said they believed in providing care to all who needed it and did give care to medically indigent patients, knowing that many bills would not be paid. Yet most patients were billed at the practice’s full fee schedule rate for the services provided. This is the qualification.

None of the private practices which functioned as a safety net had an established formal policy for reducing their fees to inadequately-insured low-income patients. Rather, they provided charity care through the ‘bad debt’ method. With few exceptions, all patients were billed for the services received. Practices varied in the vigor with which they attempted to collect delinquent bills.

The inclusion in this pilot project of one study community with a primary care practice with a public subsidy for charity care provided useful insights. The two investigators who studied that community as well as two other communities with only informal safety net providers concluded that the formal safety net is clearly better for patients than the informal safety net.

How much uncompensated care did these primary care practices provide?

The investigators were able to get an annual estimate of uncompensated care from only one practice – the only unsubsidized primary care practice in the study. In a recent year, the uncompensated care amount equaled 6.5% of net revenues. The investigators thought it likely this percent was higher in some other practices.

Could these practices afford to give away this percent of their services?

In answering this question, it is important to consider practices' payer mix. As these small town practices accepted all patients, they had substantial percentages of uninsured, underinsured and Medicaid-insured patients. Also, compared to urban practices, these small town practices may have obtained a greater share of their revenues from Medicare, since the population percent 65 and older is 19 percent higher in rural than urban areas. A 1999 MedPAC survey of physicians found that low Medicare and Medicaid reimbursement levels were especially problematic for rural physicians.

An unexpected finding of this study was that most of these primary care practices were subsidized. Eleven of the 12 private practices which 'saw all comers' were subsidized, though not explicitly to provide charity care. Four were owned by a hospital or regional health network. Seven were indirectly subsidized by the local hospital through low rents and administrative services. For these 11 practices, these subsidies almost surely enabled them to sustain a higher level of charity care and bad debt than would otherwise have been possible.

Discussion

In the communities studied in this pilot project, most of the private primary care practices in small towns were found to be informal safety net providers. It was clear that these practices played a critically important role in making primary care available to the un- and underinsured in these towns where no publicly subsidized charity care was available. A larger study is needed to determine the extent to which small town primary care practices do constitute an informal health care safety net and the adequacy of the access which they provide.

Another important topic for study is the adequacy of the revenues of small town physician practices. Findings in this pilot study suggest that these rural practices cared for disproportionate numbers of uninsured, underinsured and Medicaid patients, and also had larger Medicare patient loads than urban practices. To the extent Medicare is the payer for a disproportionate share of patients in rural practices, it is particularly important that Medicare payments are sufficient to play their part in sustaining these practices. For Medicare beneficiaries living in small rural

towns, local primary care access is directly related to the economic viability of physician practices.

The discovery that all but one of the informal safety net practices were subsidized suggests that achieving and sustaining economic viability may be difficult for independent practices. If it is found on further investigation that most small-town primary care practices need to be subsidized in order to survive, what does this mean about which small towns have local primary care and which ones do not? The study investigators noted that when the subsidizing organizations are based outside of the local communities, decisions about the local availability of primary care are being made outside of these communities.

This discovery also points to a key role of rural hospitals which is often overlooked – that of sustaining physician practices in small towns. The linch-pin role of the rural hospital as organizer of health services in the community is widely acknowledged. Findings in this study also suggest the importance of rural hospitals' support of physician practices and raise a question about the survivability of local physician practices when small town hospitals close.

Depending on the outcome of further studies, public policy makers may wish to review the programs which directly and indirectly subsidize safety net access in small towns. At the federal level, the most prominent ones are the PHS 330 Community Health Center program and the Rural Health Clinic program.

Small Town Health Care Safety Nets

Preliminary Report on a Pilot Study

Pat Taylor, Ph.D. ¹

Although the percentage of rural residents with inadequate health insurance is at least as high as the national percentage (Mueller), very little is known about rural safety net access. The purpose of this pilot study was to start building knowledge about the rural health care safety net. The study focus was on the primary care safety net in small towns where there is no publicly subsidized charity care. In these towns, the primary care safety net – if there is one – is composed of the private primary care practices. We call this the *informal safety net* — the private professionals and organizations that provide free and low cost care to people unable to pay but do not receive any public funds or other public support to compensate them for these services.

Because the medically needy in many small rural towns rely on the informal safety net for primary care, it is important that health policy makers have accurate information about that safety net. Important first questions to be answered are whether the un- and underinsured are able to get needed health care in these small towns and whether private safety net providers can afford to provide sufficient safety net care.

Background

In most small rural towns, the only primary care safety net is the informal one. Of the approximately 5,000 small rural towns (population of 1,000 to 10,000), only about 10 percent have a federally subsidized primary care clinic (PHS 330 Community Health Center), and only a

¹ The other investigators in this study were Lynn Blewett, Michelle Brasure, Kathleen Thiede Call, John Gale, Amy Hagopian, L. Gary Hart, David Hartley, Peter House, Kerry James, and Thomas Ricketts. All are co-authors of the studies to be published from this research project. Pat Taylor takes full responsibility for the interpretations of data and the conclusions in this preliminary report. She can be contacted by telephone at 202.543.2605 and e-mail at ptaylor@cpcug.org.

small percentage of others are believed to have primary care clinics subsidized by state or local governments.

A few researchers have investigated the amount of charity and uncompensated care provided by physicians in private practice. Cunningham and Tu, using 1994 AMA data, found that 68 percent of physicians provided some charity care (care provided free or at a reduced fee because of the financial need of the patient) and these physicians spent 12.4% of their direct care hours in providing charity care. Dunham, et al., studied the amounts of charity care, bad debt, and discounted Medicaid care provided in Wisconsin physician group practices in 1988. Overall, these types of care summed to 7.6% of total billings (1.6% for charity care, 3.0% for bad debt, and 3.0% for discounted Medicaid care). There was an inverse relationship by practice size in the relative amounts of charity care and bad debt. Smaller practices reported lower proportions of charity care and higher proportions of bad debt, while larger practices reported a higher proportion of charity care and a lower proportion of bad debt. The authors point out that the distinction between charity care and bad debt is nebulous as it depends on how physician practices define and track services for which no payment is received. Small practices may not have up-front procedures for providing charity care but may be more willing to write off care to patients who cannot afford to pay as bad debt. Conversely, large practices may have established policies for granting charity care but be less willing to write off unpaid bills of low-income patients. For this reason, in studies like the present one it is more useful to talk about uncompensated care, which is charity care and bad debt combined.

Study design

This pilot project was a collaborative undertaking of the federal Office of Rural Health Policy and four of the rural health services research centers funded by that office in 1999.² The research was carried out in the spring and summer of 1999 using the community case study methodology with extensive interviewing of key informants in each community.

The criteria for selection of the study communities were 1) a population of less than 5,000, 2) at least two FTE primary care physicians, 3) the next nearest town with a primary care practice is at least 30 minutes or 30 miles distant, 4) no hospital or only one hospital, 5) no primary care practice receiving a public subsidy to provide safety net care, 6) ethnic diversity: at least one community with a sizable African American population and one community with a sizable Hispanic population, 7) the percent living in poverty is at least the state average, and 8) the percent uninsured is at least the state average. With three exceptions, the eight study

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communities met all the selection criteria. One community was not a primary care service area. One had a population of more than 5,000 -- it was a very rural county with a geographically dispersed population of 12,000 living in very small towns and hamlets. And, for comparison purposes, one community with a clinic receiving a federal subsidy for safety net care was included in the study.

The eight study communities were a convenience sample, with each of the participating research centers selecting the study communities in its region. As three of the four research centers were located in northern border states, all but one of the study communities were located in northern border states or Alaska. One was in a southeastern state.

The principal questions addressed in this study were:

- C What percent of the local population needs access to safety net primary care?
- C Are people in need of safety net care able to get it?
- C How much safety net care do the private primary care practices provide?
- C What is the financial impact on the private primary care practices of providing safety net care?

In light of the small number of communities studied and the geographically non-representative character of the sample, the study findings reported here should be understood as only suggestive. Further, larger studies would be needed to assess the extent to which our findings can be generalized to and beyond the universe of small rural towns with only informal primary care safety nets.

Findings

o How many people in these communities needed access to the primary care safety net?

In seven of the eight study communities, we were not able to get solid estimates of the percent of people who needed access to safety net care. However, it was clear in every community that a substantial percentage of the population either had no health insurance or had policies with high deductibles relative to their income.

Since primary care is delivered at the community level, we expected that community leaders and health care providers would have a good sense of the percent of local people without adequate health insurance. This expectation was not met. There was a public official in only one of the study communities who had a good handle on the amount of need for safety net care. The public health director of the southeastern study community, concerned about the many residents lacking adequate health insurance, had conducted a survey of health insurance coverage to get a good estimate of that percentage. Hospitals and primary care practices were similarly uninformed on the community-wide health insurance picture. Their information on safety net

need comes from the insurance profile of their patients. They knew the percent of their total billings to ‘self pay patients’ and the annual amount of uncompensated care.

Although many of the community leaders interviewed were ill informed on safety net need, in every community most informants knew which local employers provided good health insurance and community leaders were able to estimate the number of employees at these firms. But none had gone on to use this information to estimate the number without good insurance. Of course, this is not a straightforward calculation as only one spouse in a family needs good insurance for the whole family to be well-insured.

One finding which surprised the investigators was the large percent of the local population of all communities thought to be underinsured. In every study community, local informants estimated the number of underinsured people to be at least equal to the number with no health insurance. The underinsured are those whose health insurance policies carry large deductibles relative to income and are therefore effectively uninsured for primary care. Some are employees of small firms. Small firm employees are a larger share of rural than urban employees (Coburn). In 1999 *Modern Healthcare* reported that the mean deductible was \$1,000 for rural employees with indemnity family coverage compared with \$500 for urban workers. Others are self-employed persons with individually purchased policies. The Idaho community case study contains these illustrations of underinsurance.

An Idaho primary care doctor: *“My office offers a \$3,000 deductible policy for employees; the monthly premium for my office manager, her husband and one child is \$280 -- a fourth of her income.”*

A local insurance agent: *“I tell clients who have individual policies with high deductibles, for example, \$5,000, ‘don’t file any claims unless they are really big, because these will be counted against you when your policy comes up for renewal, and it may not be renewed.’ These policies are called ‘Save the farm’ policies, to be used only once in a lifetime.”*

We developed rough estimates of the percent of inadequately insured people by study community using a combination of estimates by local key informants, recent county-level needs assessments where available, state estimates of health insurance coverage by sub-state region, and hospital and primary care practice billing records (Table 1). The estimated percent of people with inadequate health insurance in the study communities ranged from 20 percent to 40 percent.

o Were those in need of safety net care able to get it?

The answer is a qualified ‘yes’ in six of the seven study communities with no publicly subsidized safety net care. The exception was the southeastern community in which the one

primary care practice saw only insured patients and those uninsured patients able to pay cash.³ The other 12 private practices interviewed said they believed in providing care to all who needed it and they did give care to medically indigent patients, knowing that many bills would not be paid. In all of these practices, a substantial proportion of the patients were uninsured or underinsured -- our estimates of this proportion range from 15% at the low end to as high as 35% at the top end. It is likely that many of these patients found it difficult or impossible to pay their bills. Yet most were billed at the practice's full fee schedule rate for the services provided. The knowledge that they would get bills they would have difficulty paying seemed to be a deterrent to seeking care. The physician practices reported that self pay patients frequently delayed seeking care, *"They wait until they are very sick before they come in."*

As one Idaho adult whose family was without health insurance told us: *"Our problem is not getting the care we need; it's being able to pay the bill afterwards."*

These practices all willingly made "payment arrangements" with their self pay patients. Typically, the patient agreed to pay an affordable amount per month until the bill was paid off.

These practices provided a small part of their uncompensated care by choosing to not bill certain patients (probably rare), and billing some patients for less costly services than the services actually provided -- called "downcoding." However, most of the care given away by these physician practices was given through the "bad debt" method, in which charity care and bad debt are an indistinguishable mix.

Charity care provision through the "bad debt" method. None of the private practices studied had an established formal policy for reducing their fees to inadequately insured low income patients. The contrast here is with the one federally-funded (PHS 330) Community Health Center in the study which, as required, posted its guidelines for determining patient eligibility for free or reduced-rate care and had a federally subsidized sliding fee scale. All the private primary care practices billed most self pay patients at the full fee schedule rate.⁴ Some of

³ At the time of this community case study, a sick child clinic had just opened in the public health department's building. The clinic was created under a joint partnership between the public health department, the internal medicine department of a state medical school and a pediatrician who had recently moved to town. The public health department also provided space to a free clinic which served the working poor, age 16 years and older, who could not afford private insurance and did not qualify for public programs like Medicaid. This clinic, initiated by a local church, had the support of several area organizations and a totally volunteer staff of approximately 50. The clinic was open Thursday evenings from 5-7:30 p.m.

⁴ The only payers expected to pay the organization's full charge rate were uninsured / self-pay patients and commercial plans which had not negotiated discounts with the providers. Medicare and Medicaid pay providers according their respective fee schedules. Commercial carriers with substantial

these patients paid only part of the bill and then stopped paying or did not make any payments. Practices varied in the vigor with which they attempted to collect delinquent bills. Some practices wrote off selected unpaid bills as soon as two or three months and kept others on the books for a longer time period. Some practices used a collection agency; some did not. None of the practices interviewed took patients to court to collect unpaid bills, but it is possible their collection agencies did.

This method of providing charity care is a negative experience for both the physicians and the patients. By mixing together the patients who can afford to pay the full fees and those who cannot, it denies physicians and other practitioners the opportunity to perform acts of charity / altruism in an up-front manner -- to act on their altruistic beliefs. And it even denies them the opportunity to feel good about their altruism when 'bad debts' are written off -- as they likely are not able to distinguish reliably which of the debtors could reasonably have paid more of their bills and which ones could not. From the patient perspective, this method is at best unpleasant, and can be a deterrent to seeking care when a family member needs further care. Worse, it may well lead to the sacrifice of other essentials of life, and can contribute to indebtedness and perhaps to bankruptcy.

Within each practice, it seemed that the physicians and key employees made subjective judgements about which patients 'deserved' charity care and which were 'not able to pay' in making their decisions to 'not bill,' downcode, or write off unpaid bills in just a couple of months. The upside of this voluntary system is that it can be very generous. The downside is its subjective discrimination. Unpleasant people may be turned away as undeserving. And those with a record of not paying their bills may be turned away 'if they don't seem *really sick*.'

The inclusion in this pilot project of one study community with a primary care practice with a public subsidy for charity care provided useful insights. The two investigators who studied this community as well as two other communities with only informal safety net providers said:

"The formal safety net is clearly better for the patients than the informal safety net. In the rural informal safety net, the practices have no clear standards for charity care and payment arrangements were made on individual basis. There was no way to know if the practice or the practice's decision makers treated all equally. And, for the patients, there was no way to know in advance the cost of the office visit -- especially for new patients."

market share have usually negotiated formal discounts with area providers. It is ironic that the payers expected to pay the highest fees were those who could least afford them (Kolata). At the same time, it is important to be aware of the strict Medicare guidelines which must be followed by practices wishing to reduce the fees charged to low income patients with inadequate insurance. Failure to conform with these guidelines can result in Medicare charging a provider with fraud or abuse.

o How much uncompensated care did these primary care practices provide?

We were able to get an annual estimate of uncompensated care from only one practice – the only unsubsidized primary care practice in the study. In a recent year, the uncompensated care amount equaled 6.5% of net revenues. The investigators thought it likely this percent was higher in some other practices.

o Could these practices afford to give away this percent of their services?

In answering this question, it is important to consider the payer mix of practices. Giving away 5-10% of all services when the other 90-95% are well reimbursed is one matter. It is quite another matter when reimbursement is poor or barely adequate for an additional substantial percent of services. Practice size is also a consideration. Economies of scale at larger practices may increase the percentage of revenues that practices feel they can devote to charity care

Small town primary care practices may have a different payer mix than their urban counterparts. It is likely the payer mix in the primary care practices in this study was affected by their location in small towns where no publicly subsidized charity care was available and by the fact that a number of them were the only physician practice in town. Several practices talked explicitly of the professional obligation this location placed on them – the obligation to see all comers irrespective of ability to pay or adequacy of their insurers' payments. *“In a small town, you can't turn people away [because we are the only primary care doctors in town], unlike in city practices which ask the uninsured to pay up front or don't see them, and are selective about seeing Medicaid patients.”* Others spoke of the community expectation that their physician practice should see the uninsured. One practice manager said *“We know everybody here [in our small town]. If we turn away people who can't pay, we won't have a practice anyway”* [as those who can pay will find us professionally deficient and take their business elsewhere].

We speculate that these practices provided proportionally more of their services to no-pay or low-pay patients than big-town and city private practices which can refer uninsured, inadequately insured and Medicaid-insured patients to publicly subsidized practices. Also, these small town practices may receive a greater share of their revenues from Medicare. Since the population percent 65 and older is 19% higher in rural than urban places, these practices likely provided proportionally more of their services to Medicare-insured patients than do urban practices.⁵ To the extent this is the case, the adequacy of Medicare fees is more important to the

⁵ Not counting the Alaskan study community, 18% on average of the study communities' residents were 65 and older. Alaska is excluded because its notably young population makes it an outlier; residents 65 and over constituted only 7% of the population in the Alaskan community's population. Nationally in 1999, 14.5 percent of the nonmetropolitan population was 65 and older compared to 12.2 percent of the metropolitan population. In the most rural counties (Urban Continuum code 9), the percent

economic viability of rural primary care practices than urban ones. For example, excluding the Alaskan practice and extrapolating from national level data, Medicare was the payer for an estimated 25%, on average, of the office visits in these primary care practices.⁶ A Midwestern practice reported, “*We get paid by Medicare about 30% less on average than we get paid by our commercial payers. Most of them are managed care organizations, and our contracts with them are largely discounted fee for service.*”

National data on office visits to general and family physicians by expected source of income (Table 2) shed some light on the payer mix of general and family physicians. Nearly one in five (19.5%) of their patients had no insurance or were insured by Medicaid, a poor payer in many states. In light of the inadequate reimbursement received for this substantial percent of all office visits, the adequacy of Medicare’s payments for its 18% share of office visits may be particularly important to primary care physicians, especially to those whose incomes are a direct function of their practice revenues. Findings in a 1999 study conducted for MedPAC suggest that Medicare and Medicaid reimbursement levels are especially problematic for rural physicians (Schoenman and Chang). Sixty-two percent of rural physicians compared to 43 percent of urban physicians said Medicare fee-for-service reimbursement levels were a very serious problem. Seventy-five percent of rural physicians compared to only 54% of urban physicians said the Medicaid fee-for-service reimbursement levels were a very serious problem.⁷

An unexpected finding of this study was that most of these primary care practices were subsidized. Eleven of the 12 private practices which ‘saw all comers’ were subsidized, though not explicitly to provide charity care. Four were owned by a local hospital or nearby hospital or regional health network; the physicians in these practices were salaried by the owners. Of these four, two were federally certified rural health clinics and so were reimbursed on a cost basis for care of Medicare and Medicaid patients. The seven solo practices in the northwestern study community were all indirectly subsidized by the county-owned hospital through such methods as low rents in the hospital-owned medical office building and low-cost administrative support services (e.g., billing and collections). These arrangements almost surely enabled the practices to sustain a higher level of charity care and bad debt than would have been possible without these subsidies.

Only three private practices in the study communities were independent, physician-owned practices. One was the practice in a southeastern state which saw only paying patients.

was 16.7 percent. U.S. Bureau of the Census estimates, July 1999.

⁶ Estimation calculations, including data sources, available from the author.

⁷ These percentages differ from percentages for all other physicians at 0.05 significance level or better

Another, which investigators were unable to interview, was a two-physician practice in a small Midwestern town whose owners were both nearing retirement. The third and largest one, with 10 primary care physicians, was also in the Midwest. This is the practice mentioned above in which charity care and bad debt were equal to 6.5% of net revenues in a recent year. This amount of uncompensated care was of great concern to its physician owners who were reported “*to talk about it all the time.*” The annual impact of the uncompensated care amount was a reduction in income to each of its physicians of \$16,000 to \$20,000 per year. This practice expected to lose some of its young doctors “*who won’t stay here because they can’t earn enough.*”

Another factor contributing to the integration of these primary care practices with larger organizations may be their need for more administrative capacity than is efficient or affordable for small physician practices.

o Prescription drugs, tests and specialist care

The scope of this pilot project was limited to investigating access to the care that primary care physicians directly provide. For this reason, there are no study findings on the inadequately insureds’ access to prescription drugs, diagnostic tests and specialist care. But anecdotally, costs were a huge barrier to obtaining prescribed drugs and diagnostic tests. Many key informants brought up this topic as one of great concern to many in their community. Access to specialist care was mentioned much less frequently, which is not to suggest it was not also problematic.

Discussion

In the communities studied in this pilot project, most of the private primary care practices in small towns were found to be informal safety net providers. It was clear these practices played a critically important role in making primary care available to the un- and underinsured in these towns where no publicly subsidized charity care was available. The findings also show that not all small town primary care practices provide care to the medically indigent. A larger study is needed to determine the extent to which small town primary care practices do constitute an informal health care safety net and the adequacy of the access which they provide. An assessment of the degree to which these practices were able to meet the local need for safety net care was beyond the scope of this study. However it is highly unlikely that, as a group, all the private practices in any of these places could have met the care needs of the 20 to 40 percent of inadequately insured residents (Table 1) and stayed in business.

Another important topic for study is the adequacy of the revenues of small town physician practices. The pilot study findings suggest that these rural practices cared for disproportionate numbers of uninsured and underinsured patients, accepted Medicaid patients, and also had larger

Medicare patient loads than urban practices. To the extent Medicare as a payer is disproportionately important in rural practices, it is particularly important that Medicare payments are sufficient to play their part in sustaining these practices. For Medicare beneficiaries living in small rural towns, local primary care access is directly related to the economic viability of physician practices.

The discovery that all but one of the informal safety net practices were subsidized suggests that achieving and sustaining economic viability may be difficult for independent practices. If it is found on further investigation that most small-town primary care practices need to be subsidized in order to survive, what does this mean about which small towns have local primary care and which ones do not? What criteria are used by the hospitals or regional networks in determining the location of practices they are willing to subsidize? The study investigators noted that when the subsidizing organizations were based outside of the local communities, decisions about the local availability of primary care were being made outside of these communities.

This discovery also points to a key role of rural hospitals which is often overlooked – that of sustaining physician practices in small towns. The linch-pin role of the rural hospital as organizer of health services in the community is widely acknowledged. Findings in this study also suggest the importance of rural hospitals' support of physician practices and raise a question about the survivability of local physician practices when small town hospitals close.

Depending on the outcome of further studies, public policy makers may wish to review the programs which directly and indirectly subsidize safety net access in small towns. At the federal level, the most prominent ones are the PHS 330 Community Health Center program and the Rural Health Clinic program. Both programs provide qualified clinics with cost-based reimbursement up to a cap amount for services to Medicare and Medicaid insured patients. PHS 330 clinics also receive grants which support an income-related sliding fee scale and other services to low income patients. The two programs serve somewhat different rural populations; this is evident in the only partially overlapping geographic distribution of the rural clinics they subsidize (North Carolina Rural Health Research and Policy Analysis Program Cartographic Archive).

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Table 1. Estimates of Percent with Inadequate Insurance, Low Income Public Insurance, and Medicare Insurance, by Study Community

Study Community	Inadequate insurance			Low income public insur. Medicaid, other	Medicare ^ (65 & older)
	Uninsured	Underinsured ⁺	Total		
Maine #1 RHC	11% ^a	9%	20%	10% ^a	18%
Maine #2 RHC & Maine #3 CHC	20% ^a	10%+	30%	25% ^a	17%
North Carolina ^b	17%	23%	40%	13%	18%
Minnesota #1	4% + 6%*	10% ^c	20%	15%	18%
Minnesota #2	2% + 6%*	Latino factory workers, ^d farmers, self-employed	20%	12%	21%
Idaho	21%	Indiv. policy % 13%	34%	4%	15%
Alaska	23%**	[no indiv. policies are sold in Alaska]	30%	?	7%

RHC - Rural Health Clinic; CHC - Federally subsidized Community Health Center

⁺ Individually purchased policies and small firm employees

[^] Community or county population percent 65 and older

^a County health needs assessment

^b County public health department survey

^c Estimated as equal to percent uninsured

^d Ulrich EM. Public Health and & Health Care Access Issues for Minnesota's Latino Community

* Uninsured all year + uninsured part year - state estimates by sub-region

** Inpatient self-pay percent

**Table 2. Percentage of Office Visits to General and Family Practice Physicians
by Expected Source of Payment: United States, 1997***

Private Insurance	Medicare	Medicaid	Self-pay & no charge	Other	Unknown or not reported
53.3%	18.3%	9.8%	9.7%	6.8%	2.2%

* American Academy of Family Physicians web site. *1999 Facts About Family Practice*, Table 25.

Data source: US DHHS, PHS, CDC, National Health Statistics, 1997 data