Survival Strategies for Michigan's Health Care Safety Net Providers

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Objective. To understand key adaptive strategies considered by health care safety net organizations serving uninsured and underinsured populations in Michigan.

Data Sources/Study Setting. Primary data collected through interviews at community-based free clinics, family planning clinics, local public health departments, and Federally Qualified Health Centers from 2002 to 2003.

Research Design. In each of six service areas in Michigan, we conducted a multiple-site case study of the four organizations noted above. We conducted interviews with the administrator, the medical or clinical director, the financial or marketing director, and a member of the board of directors. We interviewed 74 respondents at 20 organizations.

Principal Findings. Organizations perceive that unmet need is expanding faster than organizational capacity; organizations are unable to keep up with demand. Other threats to survival include a sicker patient population and difficulty in retaining staff (particularly nurses). Most clinics are adopting explicit business strategies to survive. To maintain financial viability, clinics are: considering or implementing fees; recruiting insured patients; expanding fundraising activities; reducing services; or turning away patients. Collaborative strategies, such as partnerships with hospitals, have been difficult to implement. Clinics are struggling with how to define their mission given the environment and threats to survival.

Conclusions. Adaptive strategies remain a work in progress, but will not be sufficient to respond to increasing service demands. Increased federal funding, or, ideally, a national health insurance program, may be the only viable option for expanding organizational capacity.

Key Words. Free clinics, mission transformation, access, adaptive strategies

The U.S. health care safety net periodically comes under scrutiny because of concerns that the organizations comprising the safety net may not survive declining resources, political threats, or the increasing demand for services resulting from growth in the number of uninsured or underinsured individuals. Although many studies have addressed the financial viability of safety net organizations in specific geographic areas, none has addressed the strategic decisions these organizations confront in an increasingly difficult financial environment. We define the health care safety net as those organizations and programs, in both the public and private sectors, with a legal obligation or a

commitment to provide direct health care services to uninsured and underinsured populations.

In this article, we report the results of a multiple-site case study of the strategic adaptations Michigan health care safety net organizations have considered in response to the current environment. We examine how changes in the health care environment influence these adaptations, and the implications for access to health care among the uninsured and other underserved groups. The specific research questions we address are: What are the current threats to safety net organizations' survival? What are the adaptive strategies these organizations have considered and implemented? What are the resulting internal organizational changes? Health care safety net organizations' ability to develop and implement coping strategies will determine whether the health care safety net infrastructure survives and what types of policy interventions are required for long-term sustainability. A better understanding of how safety net organizations select among alternative responses to environmental threats can provide policymakers with information needed to ensure that uninsured and underinsured Americans have access to basic health care services.

BACKGROUND

The United States lacks a central organizing apparatus for financing health care. Despite rising numbers of people without insurance, there is no national health insurance program providing access to care for uninsured and underinsured populations. Instead, an uncoordinated patchwork of public and private resources, including hospital emergency departments, community health centers (federally and privately funded), and limited state programs, attempts to fill the gap. By most accounts, the resulting health care safety net is inadequate to meet the need, and suffers from chronic underinvestment and periodic financial crises that threaten its survival (IOM 2000; Regenstein et al. 2004). Indeed, health care safety net organizations find it increasingly difficult to maintain their missions while protecting their fiscal margins (Hegner 2001). Recent studies show that the health care safety net has survived, but add that it remains in a weak position to meet the increasing demand (Baxter and

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Mechanic 1997; Grogan and Gusmano 1999; IOM 2000; Reed and Cunningham 2001; Waitzkin et al. 2002; Felt-Lisk, McHugh, and Howell 2002; Politzer et al. 2003; Felland et al. 2003; Regenstein et al. 2004). Potential responses include: redefining the organization's target population or service mix; forming partnerships with other safety net providers in the private or public sectors; and contracting with managed care plans (Baxter and Mechanic 1997; Wall 1998; Grogan and Gusmano 1999; Felland et al. 2003; Baxter 2004).

METHODS

We used a multiple-site case study approach to conduct qualitative interviews with key informants (Yin 1994). Case study methods are appropriate for studying the dynamics of system change, particularly when the viewpoints of multiple stakeholders in complex systems are required (Yin 1994; Sofaer 1999). Although the in-depth qualitative information obtained in a small number of case studies does not produce statistical generalizations from a sample to a larger population, case studies permit investigators to draw a series of descriptive inferences (Gerring 2004).

After constructing a map of all health care safety net providers in Michigan, we identified clusters of various organizational types within a geographical area. We then selected six service areas based on the following criteria: geographic diversity; diversity of organizational types; diversity of services provided; mix of affluent and non-affluent areas. In each service area, we selected four organizations for study: a community-based free clinic, Federally Qualified Health Center (FQHC), family planning clinic, and a local public health department (LHD). We excluded hospitals because others have already studied these institutions (Brennan, Gutterman, and Zuckerman 2001; Markus, Roby, and Rosenbaum 2002). For this study, the organization is the unit of analysis. Within most of the organizations, we interviewed the administrator, the medical or clinical director, the financial or marketing director, and a member of the governing board.

We define free clinics as privately funded organizations dedicated to providing free care to the uninsured population. These organizations do not accept health insurance (either public or private), but rely on donations and grants to provide free services. The free clinics in our study include a mix of secular, church-supported, and faith-based organizations. The distinction between church-supported and faith-based clinics is that the latter incorporate an evangelical mission along with the social mission of providing health care.

FQHCs are primarily funded through section 330 of the Public Health Service Act and the Medicaid program. Federal regulations require FQHCs to serve all clients regardless of ability to pay and offer services on a sliding scale fee schedule. FQHCs must be located in an area deemed medically underserved, and the board of directors must reflect the demographic composition of the service area. Family planning organizations are defined as entities whose mission is to provide comprehensive contraceptive and family planning services to underserved populations. Funding is through the federal Title X Family Planning program, along with a mixture of private and other public sources.

As shown in Table 1, we categorized the communities into three types: rural (A and B), mid-sized urban (C and D), and urban (E and F). The county population of the communities varies significantly, ranging from just over 11,000 residents in Community A to over 2 million in Community F. Unemployment rates range from a low of 3 percent in Communities C and E to a high of 7 percent in Community A, but are rising throughout Michigan. The racial and ethnic composition of participating communities ranges from nonwhite populations of less than 5 percent (Community B) to almost half of all county residents (Community F).

Interviews

To address the research questions, we developed and pretested a semi-structured interview protocol that included questions about threats to

Table 1: Demographic Characteristics

<i>County Type</i>	<i>Population*</i>	<i>% Nonwhite*</i>	<i>% < 100% Poverty[†]</i>	<i>% Unemployed[‡]</i>	<i>% Uninsured[§]</i>
A Rural	11,333	15.3	22.6	9.5	12.7
B Rural	64,634	4.9	8.8	8.1	11.5
C Mid-sized urban	238,603	15.4	10.6	4	11.6
D Mid-sized urban	436,141	24.7	13.4	7.8	12.1
E Urban	574,335	16.9	7.7	5.8	10.6
F Urban	2,061,162	48.3	19.5	6.4	13.6

*U.S. Census (2000) Retrieved September 20, 2002 from <http://censtats.census.gov/data/MI/04026.pdf>

[†]Poverty rates based on 1999 income, and U.S. poverty levels. U.S. Census (2000) Retrieved January 10, 2004 from <http://quickfacts.census.gov/cgi-bin/lookup?state=26000>

[‡]Michigan Family Independence Agency (2002) Welfare Reform Data Monitoring. Data though June 2002. Retrieved September 20, 2002 from <http://www.michigan.gov/documents/FIA-WelfareReformMonitoring>.

[§]Rate of uninsured based on the *Characteristics of the Uninsured and Select Health Insurance Coverage in Michigan*. Michigan Department of Community Health (2001) Retrieved July 21, 2004 from http://www.michigan.gov/documents/EmployerBrief_9974_7.PDF

organizational survival, strategic responses (considered or implemented) to the threats, opportunities for organizational change, and recommendations to policymakers. We used the same protocol for all interviews, although the emphasis varied depending on the respondent's position within the organization. We conducted 74 interviews at 20 organizations (six free clinics, five FQHCs, three family planning clinics, and six LHDs).

The interviews were conducted in 2002–2003 by the first, second, and third authors. Most interviews lasted one hour (range of 30 minutes–2 hours). Each interview was tape recorded and transcribed. Because we promised confidentiality to each respondent and organization, results will be reported only in the aggregate.

Data Analysis

Following the interviews, the primary interviewer provided an organization-specific summary. Each of the investigators also read the transcribed interviews. The investigators met regularly to develop appropriate analytical categories and to identify cross-cutting themes. The first author developed the initial content theme analysis, focusing on recurring themes, which was then revised during extensive discussions among all authors. We then synthesized the organization-specific summaries to identify, compare, and contrast the common themes across organizations and respondents (Jacobson, Parker, and Coulter 1998/1999). Along with the case summaries and transcriptions, we used a qualitative software program, *NUD*IST* (N6 Qualitative Data Analysis Program 2002), to help organize our analyses.

RESULTS

Threats to Survival

One overriding threat to survival dominates our interviews: unmet need continues to rise—expanding faster than organizational capacity to meet it. This threat takes two forms: demand far exceeds organizational capacity; and there is a trend toward serving a sicker patient population. Reductions in public funding for key programs, increasing unemployment rates (and hence rising uninsurance rates), and the rising cost of providing services threaten the ability to serve existing clients, let alone respond to the increasing community needs. A free clinic director observes that “We can’t continue just what we’re doing and expect to survive. Our impact is limited and we are not meeting the community’s needs.”

With the exception of family planning clinics, none of the organizations is able to keep up with rising demand, a sicker patient population, and reduced resources. A free clinic director captured the current reality as “getting through the week, keeping the doors open, and keeping patients alive. We’re not the answer. We can’t do everything. I’ve had to come to peace with doing what we do well for those lucky enough to get in.” According to a free clinic board member, “We are always living on the edge—never sure about funding from year to year. The clinic will survive, but how well is unclear.” To an FQHC director, this means “moving from what you want to do to what you need to do to survive. The environment is so hard now that we are purely reactive—surviving day-to-day.” Despite federal funding, FQHCs “live and die with Medicaid revenues. If more uninsured come without an increase in Medicaid revenues, the clinic can’t survive.”

Patients increasingly present with multiple chronic conditions, most notably diabetes and behavioral health needs. The executive director of an urban free clinic describes client acuity levels as “through the roof.” Separate and apart from increasing acuity levels, several free clinic respondents note that patients present with a deteriorating lifestyle over time, which affects clinics’ ability to provide care (especially preventive services). “The underlying structure of their lives is the problem. Lifestyle change, such as exercise or understanding and following a diet, is not always an option.” More pointedly, a health department officer observed that “The uninsured are more disenfranchised than previously. They are on the wrong side of the law, (i.e., drug use and domestic violence), have mental health/substance use problems, have a poor (or no) family structure, and have no parenting skills. They are less capable—not just poor—with no basic skills.”

Recruiting and retaining qualified staff, particularly nurses and pharmacists, already in short supply nationally, is a challenge for most LHDs, FQHCs, and family planning organizations, primarily because of low pay. For instance, an urban health department reports hiring a nurse and then watching her leave 2 months later for a job paying twice as much. Free clinic administrators desire a greater number of volunteer providers, although their volunteer pool remains stable for now.

Adaptive Strategies

To meet these threats, the organizations have considered diverse adaptive strategies. Most are currently developing strategic plans to determine their short- and long-term approaches.

Financial. To maintain their financial viability, clinics rely to varying degrees on patient fees, fundraising efforts, and recruiting insured patients. So far, free clinics have not adopted fees. But our interviews suggest considerable debate among free clinic and FQHC respondents about the need to raise fees or, for free clinics, the eventual inability to avoid some type of fee structure (perhaps based on a sliding scale, as required in FQHCs). An FQHC board member concludes that there is “no choice but to raise the co-pay and to charge for services.” A free clinic’s executive director adds that “[T]he sad fact of the matter is that what we’ll do is we’ll start charging money that allows us to operate.” Family planning organizations and health departments have already increased their fees. Several organizations are also considering imposing some level of cost-sharing such as co-pays.

All but the LHDs emphasize fundraising as a critical strategy. A free clinic director framed the financial goal as “avoiding long-term reliance on government or foundations. The goal is self-sufficiency based on a private sector donor base.” Yet free clinics are largely dependent on a small group of local donors and therefore vulnerable to the donors’ financial status. As a board member of a mid-sized urban free clinic explains, “We need an assurance of a steady yearly income source over time, but we have no real strategy for achieving it.” In response to these concerns, one clinic emphasizes fundraising experience as a criterion for hiring a new executive director. The most sophisticated free clinic effort in our sample maintains a computerized donor constituent mailing list and sends an annual letter showing “what we’ve done, our needs, and a reply form.” The clinic also sends a letter to service clubs volunteering the executive director as a speaker and then adds the club to the donor list. To maintain volunteer relationships, the clinic invites all volunteers to dinners and parties.

Most organizations pursue funding through a mix of grants and donations. Free clinics are dependent on a limited number of local donors and foundations for their financial survival. Free clinic respondents note substantial increasing local competition for funds from other nonprofit organizations.

Grant applications usually are tied specifically to the mission or to existing programs, although some organizations pursue funding regardless of fit. Because most funding is raised through local community sources, organizations with active board involvement in fundraising efforts are more successful than those organizations without active board engagement. Clinics in poor urban and rural areas are at a clear fundraising disadvantage and are reliant on scattered donations and annual fundraising events. Clinics in more affluent areas are better able to solicit and receive funding from local foundations and businesses.

Recruiting a higher percentage of paying clients is an important strategic adaptation for FQHCs and family planning clinics. FQHCs are vulnerable to fluctuating Medicaid revenue. The transition to Medicaid managed care “nearly killed” two FQHCs because it “led to substantial disenrollments from the clinics.” Hence FQHCs plan to market to paying and insured populations. All family planning organizations target paying populations by marketing themselves as a provider of high quality reproductive health services. None of the free clinics, whose mission is to serve the uninsured, or HDs, is recruiting insured patients.

Retrenchment. Most organizations say that they are experiencing capacity constraints that limit their ability to serve the community, and some are actively considering plans to add clinic space or expand clinic hours. But retrenchment is a much more common strategy. Two of the free clinics, both in poor areas, turn away patients either by posting signs that no new patients will be accepted or cutting back on clinic hours: “Even if they are crying, we won’t let them in.” Half of the FQHCs, two rural and one urban, also resort to turning away patients or making patients wait several months for an appointment. Even free clinics considering expansion have been forced to impose restrictions on available services because of capacity constraints. FQHCs and free clinics that have not limited services still report “the need to draw the line” and “being near the saturation point.” Only one family planning organization is currently turning away patients, although all family planning organizations are considering plans to divert uncompensated care to LHDs.

Most health departments are moving away from direct primary care services to concentrate on providing population-based core public health functions (i.e., assurances, surveillance, and policy development) and have chosen to cut services, especially when other local providers are available. According to the chief health officer of one urban health department, “It’s a dead end for health departments to provide medical care. We should not be competing with the private sector for primary care. Holding onto the past won’t work.” Only the health departments from the two poorest communities, one urban and one rural, plan no service cuts, primarily because there are no private sector alternatives.

Operational Strategies. One of the consistent refrains in our interviews is whether to adopt explicit business strategies. Several respondents are attempting to operate as a business; some are adamantly opposed.

All family planning organizations, as well as a number of FQHCs and free clinics, operate under an explicit business approach or are discussing the need to do so. The executive director of a mid-sized urban free clinic explains that “A clinic needs a leader who understands business—it’s a business requiring organization, planning, and control.” Outside of rural areas, FQHCs also frame their organization as a business. A board member at a mid-sized urban FQHC argues that organizations serving the uninsured “need to look at the clinic as a business, not a political cause.” A free clinic financial officer ascribes the clinic’s survival to adopting private sector practices. “It’s like running a business—product development, staff, tax. Know your community and your business.” The same is true in LHDs, a process one respondent describes as “a cultural shift from counting widgets to measuring outcomes.”

Family planning organizations and FQHCs view maintaining a loyal customer base as a central component of their operational strategies. They are highly dependent upon word-of-mouth and paying clients who return for services on a regular basis. Therefore, family planning organizations routinely administer customer satisfaction surveys and make decisions based on client feedback. The clinical director of a family planning organization explains that “You can get all the new patients in the world but if they don’t come back . . . that’s what counts . . . if the patient returns.”

Most organizations recognize the need to improve efficiency, quality of care, and responsiveness to patients. Yet a common problem across our sample organizations is the “serious gap in the capacity to collect and analyze data.” One newly hired FQHC director expresses “shock about the lack of data being collected and analyzed and is not able to manage the organization” without it.

Our interviews reveal different perceptions of quality within organizations. Board members and staff most often describe the care provided in terms of its high quality. In contrast, some executive directors and a number of medical directors raise concerns about the abilities of the clinical and program staff to provide quality services. One medical director called the free clinic’s quality of care “equivalent to third world missionary work.” Executive directors and medical directors of FQHCs and health departments more commonly express concern about the quality of clinical care provided by staff than their counterparts in family planning organizations. Based on concerns about the ability to provide or monitor continuity of care, free clinics are re-examining which health care delivery model to follow. Our interviews reveal no consensus on the best strategy

between a comprehensive primary care model relative to an urgent care/referral approach. One clinic is shifting from a primary care strategy to an urgent care model, while another is going in the opposite direction “because primary care services were not available to meet the need.” And a third clinic has shifted away from a nurse practitioner primary care model to a multidisciplinary urgent care clinic because a “primary care model is inappropriate for a volunteer-based clinic where no continuity of care is possible.” The only consensus is that many respondents admire the integrated primary care model FQHCs use.

Partnerships. A key aspect of strategic responses is initiation or strengthening of collaborative relationships with private sector entities, including partnerships with local hospitals, participating in indigent drug programs, and utilizing volunteers. The most consistently successful collaborative strategy, from the viewpoint of respondents, is the pharmaceutical industry’s indigent drug program (IDP). One clinic director argues that the clinic “would be in major trouble if the indigent drug program were lost. Drug expenses keep rising, but the IDP is the mainstay of the clinic.”

Free clinics depend on their collaborations with community providers to establish continuity of care and fill gaps in service. Health departments contract out services to local providers and participate in community-wide coalitions to address health issues ranging from improving access for the uninsured to addressing health disparities. Family planning organizations emphasize collaboration as an important piece of their overall strategy, including contracts with local health departments (LHDs) and participation in community-wide efforts to address issues such as teen pregnancy.

Despite the emphasis on partnerships, we found considerable dissatisfaction with existing arrangements. In several instances, the partnership runs in only one direction—in favor of the hospital. All free clinic respondents complain that specialty referrals to hospitals are negligible and hospitals are simply sending uninsured patients back to the clinics. A medical director forthrightly states that hospitals have not been supportive because they “fear that the poor will expect the services or feel it’s an entitlement.” All but one free clinic, as well as most health departments and FQHCs, report problems with outside referrals, particularly for specialty care and prepayment for referrals. The executive director of a mid-size urban clinic describes her referral network as “Calling and begging. [We] can’t get clients referred—doors are closed at hospitals, private practices, and university health centers.” Another free clinic director notes that it is “hard

to penetrate staff at referring specialists—very time-consuming.” Family planning organizations, which offer a relatively well-defined service mix, do not experience problems with specialty referrals.

Free clinic administrators (and two FQHC administrators) also argue that hospitals view them more as competitors for revenue than as collaborators. One free clinic director says succinctly that “area hospitals are not supportive. A physician volunteer ordered a CT scan. The hospital vice president had a tantrum over the cost.” A rural FQHC administrator comments that the hospitals in its area, “instead of referring Medicaid or paying patients to the FQHC, send patients to the closest urban area,” limiting the clinic’s ability to cross-subsidize services for the uninsured. In one partnership, the hospital consistently delayed the clinic’s expansion plans. In another, the hospital partner is building a competing clinic “that will not serve the uninsured. [This is] a breach of trust because of discussions regarding the [FQHC’s] expansion plans.”

To be sure, there are several examples of successful partnerships. For instance, one urban free clinic emphasizes that its partnerships with community organizations encourage a strong sense of community ownership. According to the financial director, the clinic is “successful in growing because of strong connections to the hospital, the neighborhood provides input into operations, and there are other supportive institutions. Strong institutional support is needed for success. The more collaboration between clinics, the better.” Two FQHCs are exploring the possibility of contracting with hospitals to provide care for the hospital’s uninsured and underinsured populations.

Organizational Changes

The range of strategic adaptations just described occurs within an organizational context. Mission and leadership changes are the most important consequences.

Mission. A number of organizations are undergoing “mission transforming” activities, that is, fundamental changes of their original mission, particularly involving sources of revenue, the mix of services provided, and the client pools served. Mission transformation is often part of a deliberate organizational process to incorporate specific strategies to counter new threats and challenges.

As noted above, LHDs are explicitly shifting their mission from direct service provision to a more limited focus on core public health services. All of

the family planning organizations, as well as a handful of free clinics and FQHCs, have increased fees and limited services, challenging their underlying mission to serve the uninsured. As the CEO of one rural FQHC explains, “[While there is] not a formal change in mission, [we are] now saying, for the first time, that the clinic can’t serve all the uninsured who come through the door.”

Unlike health departments, FQHCs, and family planning organizations, which view themselves as permanent entities in the health care landscape, free clinics began as a temporary solution for serving the uninsured and underinsured. Initially, these organizations viewed themselves as a temporary solution to a short-term problem—serving a church-related or faith-based mission—until a more stable governmental system could emerge. Many of our free-clinic respondents say that their “goal is to go out of business. This is not the way to do business.” As one clinic director puts it, “Free clinics as gap filling is not the answer for the uninsured.” More graphically, a clinic medical director said that “Free clinics are a band-aid on an intolerable system.”

Nevertheless, most of our sample free clinics are struggling with how to define their mission after realizing that the goal of “going out of business” will not be attainable any time soon. For instance, one free clinic is “re-doing its business plan because growth within the past 18 months was beyond expectations.” The previous vision was to meet the founders’ religious and medical missions, but the clinic is now trying to determine “What it is [we] are trying to promote? What is the [clinic’s] uniqueness for funders? Who are we serving? What services are needed to address clients’ concerns?” Commenting about the change in mission and vision, another clinic director says that the original strategy of being a “gateway to care [i.e., a referral source] is no longer sufficient because services are not available to meet the need.” At present, the clinic cannot act as a primary care provider given the lack of space and providers.

To some organizations, usually free clinics in less affluent areas, mission transformation is irrelevant. No matter what happens, they can only serve a limited number of clients who cannot afford to pay. Even so, the fact that many are considering adding fees, when Michigan’s free clinics have traditionally not charged any, is indicative of their willingness to consider mission transformation strategies.

The family planning clinics in our sample have retained their core mission of providing specific reproductive services, but are changing their operating strategies. Having a national organization motivates affiliates to

operate on a financially competitive basis, and imposes clear national benchmarking expectations. (This may also apply to FQHCs.) As the financial officer from a family planning clinic noted, “We are balancing mission and the business constantly.”

Leadership. “[T]he most effective free clinics have strong leadership from the board and staff.” Yet change in leadership at the administrative level is a common theme among half of the health departments and a minority of free clinics and FQHCs. In two free clinics, the reasons for leadership turnover range from the director’s inability to develop cost-efficient strategies in a mid-sized urban clinic to lack of leadership and “sensitivity to the community and community needs” in an urban facility. In one urban health department, leadership change was clearly initiated by the county board of directors, who brought in a new chief health officer to change the department’s mission.

One FQHC board member suggests that “The clinic [requires] a unique set of skills to handle this population and work in an environment that is different from the industry standard,” demanding both professional competence and sensitivity to the community. Finding leaders willing to take on such demanding work remains a challenge, particularly in less affluent areas. A free clinic director does not want to increase the budget because she “won’t be here forever. Who will replace me and work at this salary?”

An active governing body is an equally essential factor. Weak boards are a challenge to a number of organizations, especially the FQHCs. Our respondents characterize weak boards as not actively engaged in fundraising and advocating for the organization. In one FQHC, the executive director wants “to grow the business, but the board wants to be a custodian of the budget for the community” and is resistant to the change. In this instance, the tension is partially over the community board’s concern that the expansion would negatively affect hiring from the community. In fact, only the family planning organizations and one free clinic emphasize the board’s value in helping their organizations gain a stronger presence in the community through outreach and fundraising efforts.

DISCUSSION

By definition, the organizations in our sample have survived. But as our findings demonstrate, continued survival is hardly assured, in part because of two

fundamental structural changes occurring in how health care safety net services are organized and delivered. First, our study supports previous research showing that state and local health departments are moving away from providing direct services, such as family planning and primary care, for uninsured and underinsured populations (Wall 1998; Keane, Marx, and Ricci 2001, 2002).

A second shift is in health care safety net organizations themselves, especially the free clinics. Although many free clinic respondents maintain that their goal is to go out of business, our interviews indicate that they are now an integral part of the safety net's institutional structure. The realization that their existence will not be temporary is driving respondents to confront vastly more complex decisions. Should they transform the nature of their mission to meet the burgeoning demand? Or, should they pursue their original vision of serving a smaller number of patients, even if it means turning away patients in need? How can they reconcile their original mission and vision with the realities they now face?

In addressing these questions, many respondents recognize the need to operate as a business, with greater attention to efficiency. While the small business approach may not be incompatible with the clinics' charitable mission, it certainly forces more complex operational considerations and trade-offs. For instance, it will require paying more attention to capital needs to serve existing patients as well as expanding into new markets to serve the increased community need.

Adaptive Strategies

Perhaps the best way to characterize the organizations' adaptive strategies is that they remain a work in progress. No clear consensus emerges, either within or across organizational types, as to the optimal strategies to pursue. Everyone seems to agree on the need to raise funds, establish collaborations with other health care providers (usually local hospitals), and adapt to a new way of providing health care safety net services. But there is little agreement on which strategies to adopt, and virtually no systematic evaluation of adaptive efforts to date.

What emerges from the interviews is a distinction between threats to survival and barriers to success. Mission transforming organizations, usually clinics in more affluent areas and those with direct federal financial support, are in a stronger position to expand service delivery options and are more active in soliciting funding. For those organizations, the concern is not whether they will survive; rather, they are mainly dealing with impediments to expansion. In contrast, clinics in less affluent areas have been forced to turn away

new patients or reduce services and are concerned that they might not survive at all. Under these circumstances, expanding to meet the growing need is all but impossible. All efforts are directed just to survive from day to day. The level of available community resources, particularly physician volunteers and local funding, helps explain these differences across organizations.

In this sense, the free clinics and FQHCs in our sample present strikingly different attitudes. FQHCs start out with the expectation of being permanent. This is reflected in two ways: one is that FQHCs begin with a stable funding source (the federal government); the other is that FQHCs hire physicians, while free clinics usually rely on volunteers. As a consequence, FQHCs are able to focus on the long-term, but free clinics must focus on short-term survival.

Policy and Research Implications

Our study is not designed to measure access in a rigorous, quantitative manner. All we can say with any degree of certainty is that respondents consistently report being unable to meet the demand and their concomitant assessment that the demand is not being met by other organizations. It seems inescapable that large numbers of the uninsured and underinsured populations lack reliable access to health care services and that private sector resources cannot compensate for reductions in public funding. Accordingly, a policy decision for states is to reassess the appropriateness of having LHDs abandon direct services. The arguments for retrenchment are compelling as long as services are available in the private sector. But our study seriously questions the assumption that LHDs can utilize the assurance function to monitor the delivery of health care safety net services. To put it bluntly, there are only minimal private sector safety net services to assure.

Another policy implication from our study lies in our finding that clinics maintain a complex and strained relationship with local hospitals as both partners and competitors. Clinics feel that hospitals have not permitted sufficient specialty referral arrangements, but have willingly referred non-emergency patients back to the clinics. These findings are troublesome given that public policy has encouraged public-private partnerships. If the major private sector partner is not fully committed to the arrangement, alternative strategies will need to be developed.

Access to pharmaceuticals for the uninsured and underinsured populations remains a major policy concern. Although our respondents indicate that the pharmaceutical industry's indigent drug program is a successful collaboration, our interviews raise several suggestions for improvement. For

example, reducing burdensome paperwork requirements, developing a standard application process using a web-based system, and shifting from individual patient applications to estimates of a clinic's yearly use, would improve the program. Other researchers have suggested similar criticisms of the IDP effort (Felt-Lisk, McHugh, and Howell 2002; Taylor 2004).

Health services researchers can build on this study to examine whether the trends described are cyclical or whether they represent fundamental departures from the past that will be difficult to overcome. Additional research could focus on ways to increase the effectiveness of free clinics through the identification of new technologies, information, and best practices. Studying quality of care across a range of safety net providers is equally important, as is determining which models of care are most effective.

Study Limitations

Our study has certain limitations. First, these findings may neither be generalizable to other states nor to other types of health care safety net providers. It is conceivable that selecting organizations in other parts of Michigan or in other states would have yielded different results. In many ways, however, Michigan is representative of national demographic and health care delivery trends. Michigan's population distribution by age and race/ethnicity closely mirrors that of the nation, as do Michigan's unemployment, poverty rates, and critical health indicators. Thus, we anticipate that our findings are likely to be replicated in other states.

Second, we are unable to guarantee that we have captured the full range of safety net organizations. Resources limited the number of organizations we could include, and the study is limited to organizations that have survived, excluding those that have closed.

CONCLUSION

Policymakers cannot rely on health care safety net organizations to meet the burgeoning needs of the uninsured population. Nor are public-private partnerships likely to be a panacea because private sector partners have not been fully committed to the arrangements. Increased federal funding or, ideally, a national health insurance program, may be the only viable option for alleviating the burgeoning community need for health care safety net services.

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